

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Language was added to comply with CMS final rules for person centered planning, service plan development and settings requirements.

Requirements for conflict free case management were revised to comply with CMS final rules.

Quality Improvement Strategies updated to include the Medicaid waiver management application system.

Assurances revised according to new CMS guidance and requirements and to reflect participant directed service planning and informed choice.

Therapy services (OT, PT and ST) have been removed from the waiver as they are available to all waiver members through the state plan.

Assessment and Reassessment services have been removed from the waiver as these services are now transitioning to independent in-house services conducted by KY DMS.

The Community Guide service has been eliminated from this waiver renewal, but no transition plan will be necessary as no waiver participants are currently utilizing this service.

Changes in participant directed services related to:

- * PDS services provided by relatives
- * PDS Representative responsibilities
- * Processes for Involuntary transfer from PDS services to traditional services

With the exception of the reserved capacity, as long as capacity exists, eligible applicants will be selected for waiver entrance based on the date of their waiver application. If waiver capacity is not adequate for all eligible applicants, individuals will be selected for waiver entrance based on the date of their waiver application and their category of need, with individuals requiring emergency services receiving preference over individuals who require non-emergency services. Individuals currently on the wait list for ABI waiver services, and subsequently identified by updated physician recommendation (utilizing the MAP-10 Physician Recommendation form) through annual waitlist update, as having plateaued in rehab and requiring ABI LTC waiver services, shall be placed on the ABI LTC wait list as of the date of wait list placement for ABI waiver services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A. The **State of Kentucky** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Acquired Brain Injury, Long Term Care
- C. **Type of Request:** **renewal**

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

☐ 3 years ☒ 5 years

Original Base Waiver Number: KY.0477

Draft ID: KY.008.02.00

D. Type of Waiver (select only one):

Regular Waiver 

E. Proposed Effective Date: (mm/dd/yy)

07/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

☐ **Hospital**

Select applicable level of care

☐ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:



☐ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

☒ **Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:



☐ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:



1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

☒ **Not applicable**

☐ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:



Specify the §1915(b) authorities under which this program operates (check each that applies):

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:



☐ **A program authorized under §1915(i) of the Act.**

☐ A program authorized under §1915(j) of the Act.

☐ A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☒ This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Acquired Brain Injury (ABI) Long Term waiver program was developed to serve Kentucky residents as an alternative to institutional care for individuals with acquired brain injuries who have reached a plateau in their rehabilitation level, and require maintenance services to avoid institutionalization and live safely in the community. The ABI long term care waiver completes the continuum of care by complementing Kentucky's existing ABI waiver, which focuses on intensive rehabilitation for individuals with ABI. Waiver participants must be 18 years or older, meet the level of care criteria for placement in a nursing facility, and their services in a nursing facility would qualify for payment under the State Plan for Medical Assistance. Waiver services are designed to allow participants to remain in or return to the community in the least restrictive setting. These services are not available to individuals while inpatient in a hospital, nursing facility, or ICF/IID.

This waiver program is administered by the Department for Medicaid Services (DMS). DMS utilizes contractual relationships with various entities to carry out the following waiver administrative tasks: fiscal agent services; Quality Improvement Organization functions, including determining level of care and prior authorization of services; eligibility determination and fiscal intermediary functions for services delivered through participant directed services (PDS); and oversight of these PDS functions. DMS provides regular oversight of all contractual functions.

Person-centered principles are utilized in development of the waiver participant's plan of care. This plan of care includes an in-depth assessment which includes the member's goals and preferences. ABI Long Term waiver services are provided by various community-based licensed and certified agencies. Participant Directed Services (PDS) allows waiver members to choose an alternate delivery of their non-medical waiver services by offering them the opportunity to recruit and employ community individuals as service providers.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

☒ Yes. This waiver provides participant direction opportunities. Appendix E is required.

☐ No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

☐ **Not Applicable**

☒ **No**

☐ **Yes**

- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

☒ **No**

☐ **Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- ☐ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
 - F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
 - G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
 - H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
 - I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
 - J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The State secures public input by announcing public meetings and notifications to advocate groups, as well as providers, for input on changes to the waiver. All comments and concerns voiced or submitted through public meetings, provider meetings or public comment are considered and incorporated as possible into the waiver document. Progress towards incorporating public and provider suggestions are reported through provider meetings and meetings with advocates on a regular basis. Stakeholder meetings were held on December 10 and December 17, 2015 to solicit input and suggestions from interested stakeholders on this waiver renewal. Comments and suggestions included:

1. Comment/Suggestion: Review allowed units of community living supports service to possibly mirror ABI waiver units of service to assist in maintaining individuals in the ABI LTC waiver in their homes and in their communities.

Response: DMS agrees to this review.

2. Comment/Suggestion: Additional oversight is needed to insure persons placed on the waiting list for services are more appropriate for service by community providers.

Response: DMS will institute increased screening of waiver applicants to ensure ABI LTC admission criteria are applied and met by applicants. This screening will be conducted by DMS nursing staff.

3. Comment/Suggestion: Residential providers can strengthen their admissions criteria to include a process if they admit an individual and it is later determined they are unable to meet their needs.

Response: DMS concurs.

4. Comment/Suggestion: Available non medical transport and housing options continue to be a barrier for individuals who would like to return to community living.

Response: DMS acknowledges this comment.

5. Comment/Suggestion: Suggestion was made the QIO receive on-going education in their role of reviewing assessments and approving LOC.

Response: DMS acknowledges this suggestion and currently provides on-going education to the QIO. DMS will provide increased education to the QIO regarding reviewing and approving assessments for LOC.

6. Comment/Suggestion: Require additional medical documentation supporting brain injury to be submitted with the program application to confirm primary diagnosis of brain injury.

Response: DMS agrees with this suggestion and will include the requirements for additional medical documentation to support a brain injury be included with each application.

7. Comment/Suggestion: Ensure that exclusions in waiver eligibility criteria are being effectively implemented.

Response: DMS acknowledges this suggestion and will implement increased application screening, including requiring medical documentation of brain injury, and increase education to QIO to more effectively implement waiver exclusion criteria to assist in targeting waiver services more effectively.

8. Comment/Suggestion: Due to long wait times on the ABI rehab waiver wait list, persons sometimes become more appropriate for ABI LTC services during this wait time. Suggestion was made to update the MAP 10 Physician Recommendation Form annually for wait listed individuals to identify those who have become more appropriate for ABI LTC services while they were waiting for ABI rehab waiver services. Due to the fact that these individuals have sometimes already waited for up to, or more than, 2 years for services, when MAP-10 indicates, move them to the ABI LTC wait list based on the date of their placement on the ABI rehab wait list.

Response: DMS agrees with this suggestion and will implement annual update of the MAP-10 Physician Recommendation form and when indicated, place that individual on the wait list for ABI LTC services based on the date of placement on the ABI waiver wait list to assist in providing the most appropriate services to those in need.

Waiver renewal information is posted on the DMS website and newspapers. Information is included in these posting on how to request a paper copy of the waiver and how to submit written comments.

The link to review the waiver is: CMSfinalHCBRule@ky.gov

The renewal of the ABI LTC waiver includes changes to comply with federal requirements set forth by Final Rule - CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment and CMS 2296-F 1915(c) Home and Community-Based Services Waivers (Final Rule).

The following website can be used to view the ABI LTC renewal application: <http://www.chfs.ky.gov/dms>.

If you would like to receive a hard copy of the ABI LTC waiver renewal application, please call (502) 564-4321 or email CMSfinalHCBRule@ky.gov.

Public Comment

If you wish to submit written comments regarding this public notice please do so by emailing them to CMSfinalHCBRule@ky.gov or by mailing them to the following address:

Department for Medicaid Services
ABI LTC Waiver Renewal
Commissioners Office
275 E. Main Street, 6W-A
Frankfort, Kentucky 40621

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Hoffmann

First Name:

Leslie

Title:

Director, Division of Community Alternatives

Agency:

The Department for Medicaid Services

Address:

275 East Main Street

Address 2:

6W-B

City:

Frankfort

State:

Kentucky

Zip:

40621

Phone:

(502) 564-7540

Ext: 2122

☐ TTY

Fax:

(502) 564-0249

E-mail:

Leslie.Hoffmann@ky.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:**Last Name:****First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Kentucky****Zip:****Phone:****Ext:**☐ TTY**Fax:****E-mail:**

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:**First Name:****Title:**

Agency:	<input type="text" value="Kentucky Department for Medicaid Services"/>		
Address:	<input type="text" value="275 East Main Street"/>		
Address 2:	<input type="text" value="6W-A"/>		
City:	<input type="text" value="Frankfort"/>		
State:	Kentucky		
Zip:	<input type="text" value="40621"/>		
Phone:	<input type="text" value="(502) 564-4321"/>	Ext: <input type="text"/>	<input type="checkbox"/> TTY
Fax:	<input type="text" value="(502) 564-0249"/>		
E-mail:	<input type="text" value="Steve.Miller@ky.gov"/>		
Attachments	<input type="text" value="Steve.Miller@ky.gov"/>		

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☒ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915 (c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

ABI LTC Waiver Therapy Transition Plan

Payment for waiver members' physical, occupational and speech therapies will be transitioned from the ABI waiver to the State Plan. The transition will be accomplished through the following activities:

1. Waiver providers have been notified of the change and have been provided with detailed instructions on how to enroll as a state plan provider.
2. Waiver member, family and advocate organizations have been notified about the change and the transition plan.
3. Case managers will be instructed to contact each waiver member (and representative, if there is one) who is receiving therapy services to personally educate them about the change. Case managers will also revise the person-centered plan for each member receiving therapy services to reflect a different payment source; assist the member in selecting a new therapy provider, if the current provider has elected not to enroll as a state plan provider; and coordinate with the therapy provider to assure that new prior authorizations are issued for therapy services going forward.

The Community Guide service has been eliminated from this waiver renewal, but no transition plan will be necessary as no waiver participants are currently utilizing this service.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones. To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB

settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

On March 17, 2014, updated Home and Community Based Services (HCBS) final rules became effective in the Federal Register for 1915 (c) waivers, 1915(i) state plan services, and 1915(k) community first choice state plan option. As they pertain to 1915(c) waivers, these rules include requirements for several areas of HCBS: all residential and non-residential settings, provider-owned residential settings, person-centered planning process, service plan requirements, and conflict-free case management. The goal of the HCBS final rules is to improve the services rendered to HCBS participants and to maximize the opportunities to receive services in integrated settings and realize the benefits of community living. The Centers for Medicare & Medicaid Services (CMS) is allowing five years (until March 17, 2019) for states and providers to transition into compliance with the all settings and provider-owned settings requirements. This transition plan describes the process to bring the ABI-LTC waivers into compliance with the HCBS all-settings and provider-owned settings requirements.

Introduction

The Commonwealth of Kentucky (KY) Department for Medicaid Services (DMS) operates six HCBS waivers under the 1915(c) benefit, including the Acquired Brain Injury – Long Term Care (ABI-LTC) waiver. ABI-LTC participants are adults aged 18 and older who meet nursing facility level of care and have a primary diagnosis of an acquired brain injury which necessitates supervision, rehabilitative services, and long term supports (907 KAR 3:210).

Purpose

The purpose of this transition plan is to outline the assessments that DMS has completed, and planned remedial actions to bring the ABI-LTC waiver into compliance with the HCB setting final rules. The goal of the implementation of these requirements is to facilitate the integration and access of waiver participants into the greater community, including providing opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals not receiving Medicaid HCBS.

Timeline

The overarching timeline per year for KY's transition to become compliant with the HCBS final rules is located below. The timeline highlights the major activities that will occur from the time the Statewide Transition Plan is approved by CMS through March 2019 (the date by which the transition must be completed). The timeline was developed to give providers enough time to comply with the requirements and to minimize disruption for participants through the transition. The HCBS final rules will be implemented in two rounds. The first round changes include HCB setting requirements that are simpler to implement, while the second round changes include the HCBS setting requirements that are more complex, and therefore, more challenging to implement.

ABI-LTC waiver renewal public comment period 2/25/16 – 3/25/16

Submit ABI-LTC waiver renewal to CMS 4/1/16

Develop tool for on-site reviews of providers 1/1/16 – 1/31/16

Conduct on-site reviews of providers who may require heightened scrutiny based on their submitted compliance plan template and mapping 2/1/16 – 7/31/16

Finalize list of providers who will require heightened scrutiny based upon documentation collected from compliance plan templates, mapping, and on-site visits 8/1/16 – 8/7/16

Organize documentation from compliance plan templates, mapping, on-site visits, and public comments from stakeholders for each provider who will need heightened scrutiny 8/1/16 – 9/30/16

Update statewide transition plan to include final list of providers who will require heightened scrutiny 8/8/16 – 8/15/16

Transition plan public comment period 8/16/16 – 9/15/16

Submit updated transition plan to CMS 9/30/16

CMS conduct heightened scrutiny of providers 1/1/17 – 12/31/17

Host public forums for providers and participants (families, advocates, etc.) 4/1/17 – 6/30/17

Develop HCBS evaluation tool (monitoring tool for determining compliance) 7/1/17 – 9/30/17

Develop compliance plan template for second round changes 7/1/17 – 9/30/17

Host webinars for providers and distribute compliance plan template 10/1/17 – 1/1/18

Determine regulation language with workgroup for second round of changes 1/15/17 – 5/1/17

Draft revised regulations 5/1/17 – 8/1/17

Review regulations by department/leadership 8/1/17 – 12/31/17

Review and approve/deny heightened scrutiny providers' plans for compliance 1/1/18 – 3/1/18

Implement relocation plans for participants who are receiving services from providers who are deemed not to be home and community-based based on heightened scrutiny 3/1/18 – 12/31/18

Deadline for providers to submit compliance plans for second round changes 5/15/18

Incorporate second round HCBS final rules in all ongoing reviews 7/1/18

Submit revised regulations 1/1/18

Regulation public comment period 1/1/18 – 2/28/18

Regulations become effective 7/1/18

Regulations are implemented (state and providers must be fully compliant) 1/1/19

Regulation and Waiver Application Assessment

To evaluate the compliance of the ABI-LTC waiver with the HCBS final rules, DMS established a regimented process led by a workgroup of staff from three departments representing each waiver from across the Cabinet for Health and Family Services (CHFS). The review included a detailed analysis of each waiver regulation, including manuals incorporated by reference, each application approved by CMS, and related state regulations, such as provider and enrollment regulations, against each requirement of the federal HCBS rule.

The workgroup categorized and color-coded state regulations and applications into three groups: 1) State policy and requirements meet the final rules (green); 2) State policy and requirements have similar language to the final rules, but need to be strengthened (yellow); and 3) State policy and requirements do not specifically address all provisions of final rules, so language needs to be added (red).

For group one, no action is required. For group two, language and requirements in state policy have similar language to the final rules, but need to be strengthened. While some operational practices comply with the federal standards, state policies do not fully meet the final rules, and therefore, DMS needs to implement policy changes. For group three, current state policy does not specifically address all provisions of final rules, so language needs to be added. While some operational practices have similar intent to the federal standards, they do not fully meet the final rules and therefore, DMS needs to add additional requirements to policies.

Below is the summary analysis of the ABI-LTC waiver as it relates to the HCBS final rules. DMS will need to update waiver policies (regulations), operational areas, and monitoring practices to comply with the final rules. The tables below contain only the applicable HCBS final rules or applicable parts of the HCBS final rules. All HCBS final rules that were edited for the purposes of this document are indicated with an asterisk (*).

ABI-LTC Waiver – Residential (907 KAR 3:090 & 907 KAR 3:210; 907 KAR 7:005)

Not compliant; minor changes required. State policy and requirements have similar language to the final rules, but need to be strengthened.

- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Facilitates individual choice regarding services and supports, and who provides them.
- Each individual has privacy in their sleeping or living unit.
- Individuals are able to have visitors of their choosing at any time.

Not compliant with the following rules. Federal language and requirements do not currently exist in state policy and requirements and need to be added.

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Home and community-based settings do not include the following:

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.*

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to the jurisdiction's landlord/tenant law.

- Units have entrance doors lockable by the individuals, with only appropriate staff having keys.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have freedom to furnish and decorate their sleeping and living areas within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- The setting is physically accessible to the individual.

Modifications to provider-owned settings:

- o The requirements must be documented in the person-centered service plan in order to modify any of the criteria.
- o The person-centered service plan be reviewed, and revised upon reassessment of function need, at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
- o Identify a specific and individualized assessed need.
- o Document the positive interventions and supports used prior to any modifications to the person centered service plan.
- o Document less intrusive methods of meeting the need that have been tried but did not work.
- o Include a clear description of the condition that is directly proportionate to the specific assessed need.
- o Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
- o Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- o Include informed consent of the individual.
- o Include an assurance that interventions and supports will cause no harm to the individual.

Monitoring Process Assessment

DMS has set monitoring requirements for the ABI-LTC providers operating in KY and these monitoring processes will continue while

providers comply with the HCBS final rules. The workgroup outlined these monitoring processes, including the oversight process and participant and provider surveying process. Each process was then analyzed to determine the impact of the HCBS final rules and areas requiring revision were identified. Some monitoring tools will need to be updated to incorporate the new federal requirements so that CHFS waiver staff evaluates providers appropriately. If necessary, KY will increase the frequency and percentage of providers selected for review to confirm that CHFS waiver staff effectively track provider compliance. After providers have fully implemented the HCBS final rules, monitoring processes will continue with compliant tools and standards. Table 3.5 below describes the current monitoring/oversight process for each waiver, the participant and/or provider surveys that are conducted, and the areas that will need to be updated to comply with the HCBS final rules. If the department acts regarding a certified waiver provider due to the provider's behavior in one 1915(c) HCBS waiver program, the action regarding the certified waiver provider shall apply in every 1915(c) HCBS waiver program in which the provider is participating. PDS is specifically separated in Table 3.5 since PDS for all waivers is centrally monitored by CHFS waiver staff through separate waiver monitoring processes.

Current Oversight Process

- Every agency must be certified by state staff prior to the initiation of a service (new agencies are reviewed at regular intervals)
- Every agency is re-certified annually by state staff to validate compliance
- The certification process includes monitoring throughout the year and is based on compliance with state regulation
- Case managers track agencies and locations as an additional line of monitoring
- If there are reported issues/complaints, then the state staff might conduct a site visit, review the agency, investigate the issue, or refer the issue to the Office of Inspector General (OIG)
- The citation and sanctions process is outlined in regulation
- ABI/ABI-LTC participant surveys are distributed annually by state staff
- The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules
- State staff do not base their evaluations on all of the new HCBS rules
- Case managers do not base their agency monitoring on all of the new HCBS rules
- Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence

Provider Assessment

To determine the providers' compliance level, the workgroup used provider surveys as an initial estimate and followed up with more detailed compliance plan templates. Providers "self-assessed" their compliance with the HCBS final rules through surveys. The CHFS waiver staff reviewed the survey results, validated each provider's response, and assigned each provider a level of compliance. After the review of the provider surveys, the state required providers to complete a compliance plan template, where the providers were asked to provide more detailed information to demonstrate their current compliance or describe how they would become compliant. The state began reviewing compliance plan templates as they were received and used the following methods of validating the providers' responses:

- Staff review: CHFS waiver staff, including Quality Assurances (QA), who are familiar with the providers reviewed each of the surveys
- Mapping: Each setting location of the provider was mapped to determine its proximity to any non-HCB settings (institutions, nursing facilities, etc.) as well as co-located and operationally related HCB settings

For providers who remain in category 4 after the state's validation process, DMS will be conducting an on-site visit to confirm that the provider will need to undergo heightened scrutiny. The on-site assessment process will be developed with input from self-advocates, family members, advocates, and providers. During that on-site visit, the CHFS waiver staff will seek to conduct interviews with participants about their experiences to assist with the heightened scrutiny process. Any setting that remains in category 4 after the on-site visit will be published for public comment in the next iteration of the statewide transition plan. After the public comment period is complete, the DMS will submit the providers and all documentation to CMS for heightened scrutiny.

Below are the updated categorizations of provider compliance for both residential and non-residential providers, based upon initial surveys, compliance plan templates, and the state's validation process. Providers will have ample opportunity to review their compliance level and make modifications where possible to come into compliance. Providers were notified of their updated compliance level in November 2015.

Residential Settings

As part of evaluating provider compliance with the HCBS final rules, the workgroup conducted a web-based survey in June 2014 for residential providers to measure each provider's compliance level with the rules. The workgroup drafted questions using language provided by CMS, and included text boxes for providers to offer additional information for each requirement of the rule. The workgroup then summarized the provider data to establish initial estimates of compliant/non-compliant providers.

After analyzing the providers' self-reported compliance level, CHFS waiver staff from each residential waiver thoroughly reviewed provider responses. The purpose of this review was to validate that the survey responses submitted align with what has been observed by CHFS waiver staff during regular on-site provider evaluations. The workgroup selected the CHFS waiver staff to complete this validation because of their deep knowledge and experience with the residential providers. After completing survey validation, the workgroup categorized each residential provider into one of four compliance levels, as defined by CMS:

- Fully align with the federal requirements
- Do not comply with the federal requirements and will require modifications
- Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals
- Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

In order to more accurately evaluate providers, the state required each provider to complete a compliance plan template. After the compliance plan templates were reviewed and validated through the state's process, each provider's compliance level was updated based on

the additional information. The updated results of the residential provider survey, validation by CHFS waiver staff, compliance plan template, and mapping are outlined below.

All Residential Providers:

Provider only has settings that fall under Category (1) Fully align with the federal requirements: 0

Provider only has settings that fall under Category (2) Do not comply with the federal requirements and will require modifications: Level I: 72 Level II: 26

Provider only has settings that fall under Category (3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals: 0

Provider only has settings that fall under Category (4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process): Level I: 6 Level II: 0

Provider has settings that are in both categories (2) and (4): Level I: 33 Level II: 9

All Residential Settings:

(1) Fully align with the federal requirements: 0

(2) Do not comply with the federal requirements and will require modifications: Level I: 1,063 Level II: 373

(3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals: 0

(4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process): Level I: 249 Level II: 3

Non-Residential Settings

In addition to a survey targeted for residential providers, the workgroup created a similar survey for non-residential providers that focused on the HCB setting requirements. The workgroup developed this survey using CMS' toolkits and distributed it to non-residential providers via email and provider letters. The non-residential survey is outlined in Appendix B. The target provider types for this survey were ADHCS, home health agencies, day training (DT), and other non-residential waiver providers, such as case managers, who render services to the waiver population.

Since there was not 100% participation by non-residential providers, DMS required 100% participation of the compliance plan template from all providers who render services to HCBS waiver participants. Similar to the residential survey data, after receiving providers' responses, the workgroup analyzed the providers' self-reported compliance level. The CHFS waiver staff reviewed and validated the survey responses and the workgroup then categorized each non-residential provider into one of four compliance levels, as defined by CMS:

- Fully align with the federal requirements
- Do not comply with the federal requirements and will require modifications
- Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals
- Are presumptively non-HCB but for which the state may provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

The results of the non-residential provider survey, compliance plan templates, and the state's validation process are outlined below. If a provider serves participants across waivers, and/or renders both DT and ADHC, the provider was only counted once. The number of providers represents both the number of provider agencies, and the number of non-residential setting locations. Please note, case management and home health agencies who provide services only in the home are not included in the counts. If a provider operates both residential and a non-residential day program, they were counted twice.

All Non-Residential Providers:

Provider only has settings that fall under Category (1) Fully align with the federal requirements: ADHC: 3 DT: 4 Supported Employment: 2 Behavior/Community Support: 7

Provider only has settings that fall under Category (2) Do not comply with the federal requirements and will require modifications: ADHC: 63 DT: 110 Supported Employment: 4 Behavior/Community Support: 35

Provider only has settings that fall under Category (3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals: 0

Provider only has settings that fall under Category (4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process): ADHC: 9 DT: 1 Supported Employment: 0 Behavior/Community Support: 0

Provider has settings that are in both categories (2) and (4): ADHC: 0 DT: 0 Supported Employment: 0 Behavior/Community Support: 0

All Non-Residential Settings

(1) Fully align with the federal requirements: ADHC: 13 DT: 4 Supported Employment: 2 Behavior/Community Support: N/A

(2) Do not comply with the federal requirements and will require modifications: ADHC: 74 DT: 191 Supported Employment: 12 Behavior/Community Support: N/A

(3) Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals: 0

(4) Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process): ADHC: 9 DT: 3 Supported Employment: 0 Behavior/Community Support: N/A

Remedial Strategies

DMS will implement several strategies over the next five years to transition policies and operations into compliance with the HCBS final rules. The strategies identified in this section are the results of assessments completed to date.

State Level Remedial Strategies

Policy

The workgroup completed a thorough review of waiver regulations and applications, as outlined in section III. The overarching goal is for each regulation and waiver application to be in compliance with the HCBS final rules.

DMS is implementing the HCBS final rules in two rounds to assure that providers have adequate time to become compliant with all rules. While the second round of changes will not be effective in KY regulations until 2019, DMS and its operating agencies will be educating providers of these requirements and providing technical assistance to help them move toward compliance beginning in 2015. This education will be conducted through webinars, forums throughout the state, as well as through individual site visits and discussions with providers. The timeline of 2019 was selected primarily to allow more time for providers to implement these more time-consuming changes. Additional reasons for the extended timeline are as follows.

1. The rules included in the second round may have a significant impact on KY HCBS providers and create an access issue depending on the number of providers who will lose the ability to render services because of the rules, if adequate time is not allowed for implementation.
2. DMS has allotted a full year to work with the high volume of providers who will need to undergo heightened scrutiny to assure that DMS can spend adequate time working with each provider.
3. DMS is giving time for providers to stabilize the first round of changes before moving into the second round.
4. DMS will be educating providers as soon as the rules are fully defined and operationalized. The education and compliance process for the second round changes will start before 2018, giving providers ample time to become compliant.

DMS will submit revised ordinary regulations for setting-related rules in two rounds in order to allow stakeholders time to review and providers time to implement. The HCBS final rules will be implemented in two rounds based on the ease of implementation and complexity of the change. DMS drafted the regulation language for the first round from January 1, 2015 to February 28, 2015. The first round of revised ordinary regulations were filed in August 2015 and will be effective in February 2016. DMS will draft the regulation language for the second round from January 2017 to August 2017, and leadership will begin their review in August, 2017. The second round of revised ordinary regulations will be submitted in January 2018, with an effective date in July 2018, and an implementation date of January 2019. The implementation date of January 2019 is when all providers must be compliant with all HCBS settings final rules.

2. Operations

CHFS waiver staff and the workgroup will be preparing operational practices for compliance over the next three years. This includes developing a tool for providers that outlines the federal requirements and how they will be evaluated, along with hosting a webinar for waiver providers. Once updated state policies take effect, CHFS waiver staff will transition from current operational practices to revised, compliant protocols to administer the HCBS waivers. The HCBS final rules affect several areas of DMS' waiver operations including, but not limited to, internal processes, monitoring, and service delivery.

3. Participants

The significance of the changes to DMS' HCBS waivers warrants continuous communication with waiver participants and advocacy groups that communicate with participants and their families. Communicating regularly with participants also provides opportunities for CHFS waiver staff to conduct further monitoring of providers. In addition to public notices, CHFS waiver staff will organize outreach to participants to inform them of the key changes to their programs, and confirm they understand their rights. In certain cases, participants may need to be relocated based upon the results of the provider assessments. If the provider falls under compliance level three (not compliant and never will be), CHFS waiver staff will follow the same protocols to relocate participants as currently are in place when providers are terminated.

4. Technology

In April 2015, the Medicaid Waiver Management Application (MWMA), which converts the majority of waiver processes to a central online system, was implemented. The system tracks the application, assessment, and service plan process. Many of DMS' existing waiver forms have been switched from paper to electronic through MWMA, and the HCBS setting final rules impact the language that must be included on the MWMA screens.

Plan of care/prior authorization form, long term care facilities and home and community based program certification form, Medicaid waiver assessment form, SCL demographic and billing information form, and SCL freedom of choice and case management conflict exemption form

- Modify forms/screen within MWMA to comply with HCBS rules

Provider Level Remedial Strategies

As described in section III, the workgroup categorized providers into four compliance levels: 1) fully aligned with federal requirements and require no changes, 2) do not comply with federal requirements and require modifications, 3) cannot meet the federal requirements and require removal from the program and relocation of individuals, and 4) presumed not to be HCB and requires heightened scrutiny. The compliance level of each provider was determined based on surveys, CHFS waiver staff knowledge, compliance plan templates, and mapping, but these are not yet finalized.

The compliance plan template is a tool that the HCBS workgroup developed with input from stakeholders to assist providers in identifying potential areas of non-compliance. This tool is meant for collaboration and is not a corrective action plan. The HCBS workgroup developed templates for each type of provider (case management, residential, non-residential, and any combination of these). Then, each provider received an individualized template containing their responses to the surveys, if the provider participated in the survey, as well as additional questions that the provider must answer. These additional questions have assisted in providing sufficient information to DMS about the current compliance of the provider. Lastly, the provider was asked for their plan for compliance for each of the federal rules that apply. The completed compliance plan template will be continuously used to facilitate discussions with providers about their compliance as well as assist DMS with ongoing monitoring of providers.

CHFS waiver staff will implement the following activities from January 2015 to July 2018 to assist providers in transitioning to compliance.

1. Develop an HCBS evaluation tool (monitoring tool) and HCBS compliance plan template for providers to be notified of their initial

compliance and identify actions they will complete to address areas of non-compliance

a. Distribute HCBS compliance plan template to providers and inform them of their compliance levels

b. First round: January 2015 to March 2015

c. Second round: July 2017 to September 2017

2. Develop and implement HCBS final rule communication plan for providers and stakeholders through webinars, presentations at conferences, and provider association meetings

a. The HCBS compliance plan template will follow similar protocols to the current waiver provider corrective action plan (907 KAR 7:005 – section 4)

b. First round: April 1, 2015 to April 30, 2015

c. Second round: October 2017 to January 2018

3. CHFS waiver staff will review and approve/deny providers' plans

a. First round: May 2015 to October 2015

b. Second round: January 2018 to June 2018

4. Conduct routine evaluations and on-site assessments with the updated HCBS evaluation tool to validate each provider's compliance plan and level of compliance

a. Both rounds: March 2015 to ongoing

For providers in compliance level one (fully align with federal requirements), there will be no changes required of the provider and they can continue providing services. CHFS waiver staff will continue to monitor these providers and participants with on-site visits to verify compliance based on each waiver's updated monitoring process (as outlined in section III).

For providers in compliance level two (do not comply and require modifications), changes are required for the provider to become compliant with the HCBS setting rules. These changes may be short-term (0-3 months) or long-term (3-12 months), but all changes must be completed before the updated state policies are implemented in January 2019. The remedial activities included in Table 5.5 below are examples of activities that the providers may complete to come into compliance with the HCB setting rules. CHFS waiver staff will implement the following activities from January 2015 to July 2018:

1. Track provider compliance plans

a. First round: May 2015 to October 2015

b. Second round: January 2018 to June 2018

2. Conduct routine on-site monitoring to review providers' progress towards complete compliance

a. Both rounds: March 2015 to ongoing

3. For non-compliant providers, each waiver will follow the termination process outlined in Kentucky regulations

For providers in compliance level three (not compliant and never will be), DMS will complete an additional on-site meeting with the provider to confirm that the setting does in fact fall under compliance level three. If CHFS waiver staff determine the provider should not be in compliance level three, then they will fall under compliance level four and will require heightened scrutiny. If after the on-site meeting, the setting is confirmed to be in compliance level three, CHFS waiver staff will offer the opportunity for the provider to relocate the setting before the updated state policies become effective. If the provider is able to successfully relocate to a setting that complies with the federal requirements and is able to assure that operations in that setting comply with the HCBS rules, the provider will not be terminated. Should a provider not comply or qualify with HCBS rules for a particular service, they could potentially provide other HCBS services, as long as they comply with the applicable HCBS requirements for those services. However, if the provider chooses not to relocate, is unable to find an appropriate setting, or is unable to come into compliance with the HCBS rules, the provider will be terminated. The provider's termination will be based on 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) after revised waiver regulations are effective.

Participant Relocation Process: DMS will identify the waiver participants who will be impacted by provider termination and the process will be outlined. All affected participants will be relocated following the current relocation process. The process will include a person-centered team meeting, where the participant will be given the opportunity, the information, and the supports necessary to make an informed choice of an alternate setting. The CHFS waiver staff will provide reasonable notice and due process to all parties. The transition from the non-compliant provider will not occur until all critical service and supports are in place for the participant to assure consistency in services.

1. Settings presumed not to be HCB (heightened scrutiny process)

For settings in compliance level four (presumed not to be HCB), providers will be required to submit documentation to the state first, outlining how their settings do not have the qualities of an institution and do have the qualities of a HCB setting. The on-site assessment process will be developed with input from self-advocates, family members, advocates, and providers. DMS will conduct an on-site assessment, from 2/1/16 to 7/31/16 for each category 4 setting, and will coordinate closely with these providers to verify they are providing the necessary documentation to prove they have the qualities of a HCB setting. DMS will corroborate provider documentation and send the documentation to CMS for the heightened scrutiny process by 9/30/16. To assist providers in establishing documentation that they have the qualities of a HCB setting, CHFS waiver staff will complete the following activities from November 2015 to September 2016.

1. Notify providers that they may need to undergo heightened scrutiny

2. Collaborate with providers on additional documentation that must be presented as evidence of being HCB

3. Develop the tool for on-site reviews of providers in category 4

4. Conduct additional detailed on-site visits to obtain further compliance documentation

5. Submit provider's documentation to CMS for determination

For non-compliant providers or providers determined not to be a HCB setting after heightened scrutiny is conducted by CMS, the termination process outlined in regulation 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of

Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) will be followed. If the provider is terminated, the aforementioned participant relocation process will be implemented.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- ☒ **The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- ☒ **The Medical Assistance Unit.**

Specify the unit name:

Department for Medicaid Services

(Do not complete item A-2)

- ☐ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- ☐ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

DMS contracts with a non-governmental agency to provide services as a Quality Improvement Organization (QIO) and Fiscal Agent. The QIO determines level of care, prior authorizes requests for services and approves the person-centered plan of care. The fiscal agent provides processing and payment of provider claims. Financial Management services for waiver members utilizing participant directed opportunities are monitored through the Commonwealth of Kentucky's Department for Aging and Independent Living (DAIL). DAIL's responsibilities include providing supports for members choosing to participate in non-medical, participant-directed waiver services.

☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

☒ **Not applicable**

☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Department for Medicaid Services (DMS) is directly responsible for assessing the performance of contracted entities providing Fiscal Agent and Quality Improvement Organization functions, as well as participant-directed functions.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DMS assesses the performance of the contracted agencies continually through policy clarification, post payment auditing processes, second line monitoring, monthly, quarterly, and yearly reporting.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
- In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage of Utilization Management Reports completed in a timely manner by the Fiscal Agent.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
---------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------	--------------------------------------------------------------

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal agent, QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal agent, QIO	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The DMS contracts with the fiscal agent who in turn contracts with the QIO for medical necessity review. DMS and the fiscal agent meet on a quarterly basis, and as needed, to review and identify issues/problems related to the level of care, plan of care and prior authorization of services. Should problems be identified, then a collaborative plan is developed to resolve the issue/problem.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Identified problems are researched and addressed by the DMS and the Fiscal Agent through the use of Utilization Management Reports that are generated on a monthly basis. DMS monitors the Fiscal Agent to ensure that contract objectives and goals for LOC are met as appropriate. Should the Fiscal Agent not meet the requirements then a corrective action plan is required and/or a recoupment of funds could occur.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
-----------------------------------------------------	---------------------------------------------------------------------------------

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal agent, QIO	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301 (b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input checked="" type="checkbox"/>	Brain Injury	18		<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

- b. Additional Criteria.** The State further specifies its target group(s) as follows:

Individuals served through the ABI Long Term Waiver are those individuals with acquired brain injury who have reached a plateau in their rehabilitation level, and require maintenance services to avoid institutionalization and live safely in the community. An acquired brain injury is an injury to the brain which is not hereditary, congenital or degenerative. Acquired brain injury includes central nervous system injury from physical trauma, anoxia or hypoxic episodes and allergic conditions, toxic substances and other acute medical/clinical incidents. Acquired brain injury does not include strokes treatable in nursing facilities providing routine rehabilitation services, spinal cord injuries in which there are no known or obvious injuries to the intracranial central nervous system, progressive dementia, depression, psychiatric disorders or other mentally impairing conditions, developmental disability, congenital anomalies or disorders, conditions which cause the individual to pose an unmanageable level of danger to the community or medical conditions of a chronic, degenerative nature.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- ☒ **Not applicable. There is no maximum age limit**
- ☐ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☒ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- ☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

- ☐ **Other**

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (*select one*):

- ☐ **The following dollar amount:**

Specify dollar amount: **The dollar amount** (select one)

- ☐ Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- ☐ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- ☐ The following percentage that is less than 100% of the institutional average:

Specify percent:

- ☐ Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☐ Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants

Waiver Year	Unduplicated Number of Participants
Year 1	400
Year 2	400
Year 3	400
Year 4	400
Year 5	400

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ☒ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ☐ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ☐ **Not applicable. The state does not reserve capacity.**
- ☒ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
ABI LTC MFP Transitions	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup)*:

ABI LTC MFP Transitions

Purpose *(describe)*:

To incorporate individuals with an acquired brain injury transitioned from an ICF/IID or NF who utilized the Money Follows the Person grant.

Describe how the amount of reserved capacity was determined:

Capacity is reserved for Money Follows the Persons grant members who will admit into the ABI LTC Waiver as transitioned from ICF/IID and NF facilities. Capacity is reserved based on the projected number of transitions from the MFP program. Projections are based on current transition trends.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	80
Year 2	80
Year 3	80
Year 4	80
Year 5	80

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.**

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

With the exception of the reserved capacity, as long as capacity exists, eligible applicants will be selected for waiver entrance based on the date of their waiver application. If waiver capacity is not adequate for all eligible applicants, individuals will be selected for waiver entrance based on the date of their waiver application and their category of need, with individuals requiring emergency services receiving preference over individuals who require non-emergency services. Individuals currently on the wait list for ABI waiver services, and subsequently identified by updated physician recommendation (utilizing the MAP-10 Physician Recommendation form) through annual waitlist update, as having plateaued in rehab and requiring ABI LTC waiver services, shall be placed on the ABI LTC wait list as of the date of wait list placement for ABI waiver services.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- ☒ §1634 State
- ☐ SSI Criteria State
- ☐ 209(b) State

2. Miller Trust State.Indicate whether the State is a Miller Trust State (*select one*):

- ☐ No
- ☒ Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ Low income families with children as provided in §1931 of the Act
- ☒ SSI recipients
- ☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- ☐ Optional State supplement recipients
- ☐ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☐ 100% of the Federal poverty level (FPL)
- ☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR §435.330)
- ☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- ☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

The federal regulatory criteria for eligibility groups that are covered under the State Medicaid Plan that the state proposes to include under this waiver renewal includes:

42 CFR 435:110 Parents and other caregiver relatives

42 CFR 435:116 Pregnant Women; and

42 CFR 435:118 Children

Special home and community-based waiver group under 42 CFR §435.217 *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ☐ No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*
- ☒ Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- ☒ All individuals in the special home and community-based waiver group under 42 CFR §435.217
- ☐ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- ☐ A special income level equal to:

Select one:

- ☐ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- ☐ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
- ☐ Aged and disabled individuals who have income at:

Select one:

- ☐ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

- ☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- ☒ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ☐ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (2 of 7)**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

- ☐ **The following standard included under the State plan**

Select one:

- ☐ **SSI standard**
☐ **Optional State supplement standard**
☐ **Medically needy income standard**
☐ **The special income level for institutionalized persons**

(select one):

- ☐ **300% of the SSI Federal Benefit Rate (FBR)**
☐ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ☐ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☐ **Other standard included under the State Plan**

Specify:

- ☐ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ☒ **The following formula is used to determine the needs allowance:**

Specify:

SSI standard plus \$20 general exclusion

- ☐ **Other**

Specify:

ii. Allowance for the spouse only (select one):

- ☒ **Not Applicable**
☐ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ☐ SSI standard
☐ Optional State supplement standard
☐ Medically needy income standard
☐ The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

- ☐ Not Applicable (see instructions)
☐ AFDC need standard
☒ Medically needy income standard
☐ The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

Specify:

- ☐ Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
 b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☐ Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
☒ The State does not establish reasonable limits.
☐ The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- ☐ SSI standard
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☐ The special income level for institutionalized persons
- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

- ☒ The following formula is used to determine the needs allowance:

Specify formula:

SSI Standard plus the \$20 General Exclusion

- ☐ Other

Specify:

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ☒ Allowance is the same
- ☐ Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☐ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☒ **The State does not establish reasonable limits.**
- ☐ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

- i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- ☒ **The provision of waiver services at least monthly**
☐ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ☒ **Directly by the Medicaid agency**
☐ **By the operating agency specified in Appendix A**
☐ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ☐ **Other**
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The individual who performs the initial evaluation of level of care for waiver applicants must be a registered nurse, or an individual who has a Bachelor's degree or higher degree in an approved human services field, from an accredited college or university; or a Bachelors degree in any other field from an accredited college or university with at least 1 year experience working directly with individuals with brain injury.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A patient status decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.

(1) For an admission and continued stay, an individual shall qualify under the preadmission screening and resident review criteria specified in 42 U.S.C. 1396r and 907 KAR 1:755.

(2) An individual shall qualify for high-intensity nursing care if:

(a) On a daily basis:

1. The individual's needs mandate:

- a. High-intensity nursing care services; or
b. High-intensity rehabilitation services; and

2. The care can only be provided on an inpatient basis;

(b) The inherent complexity of a service prescribed for an individual exists to the extent that it can be safely or effectively performed only by or under the supervision of technical or professional personnel; or

(c) The individual has an unstable medical condition manifesting a combination of at least two (2) or more care needs in the following areas:

1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;
2. Nasogastric or gastrostomy tube feedings;
3. Nasopharyngeal and tracheotomy aspiration;
4. Recent or complicated ostomy requiring extensive care and self-help training;
5. In-dwelling catheter for therapeutic management of a urinary tract condition;
6. Bladder irrigations in relation to previously indicated stipulation;
7. Special vital signs evaluation necessary in the management of related conditions;
8. Sterile dressings;
9. Changes in bed position to maintain proper body alignment;
10. Treatment of extensive decubitus ulcers or other widespread skin disorders;
11. Receiving medication recently initiated, which requires high-intensity observation to determine desired or adverse effects or

frequent adjustment of dosage;

12. Initial phases of a regimen involving administration of medical gases; or
13. Receiving services which would qualify as high-intensity rehabilitation services if provided by or under the supervision of a qualified therapist, for example:
 - a. Ongoing assessment of rehabilitation needs and potential;
 - b. Therapeutic exercises;
 - c. Gait evaluation and training performed by or under the supervision of a qualified physical therapist;
 - d. Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility;
 - e. Maintenance therapy if the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance;
 - f. Ultrasound, short wave, and microwave therapy treatments;
 - g. Hot pack, hydrocollator infrared treatments, paraffin baths, and whirlpool (if the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications, and the skills, knowledge, and judgment of a qualified therapist are required); or
 - h. Services by or under the supervision of a speech pathologist or audiologist if necessary for the restoration of function in speech or hearing.

(3) An individual shall be determined to meet low-intensity patient status if the individual requires, unrelated to age appropriate dependencies with respect to a minor, intermittent high-intensity nursing care, continuous personal care or supervision in an institutional setting. In making the decision as to patient status, the following criteria shall be applicable:

- (a) An individual with a stable medical condition requiring intermittent high-intensity nursing care services not provided in a personal care home shall be considered to meet patient status;
- (b) An individual with a stable medical condition, who has a complicating problem which prevents the individual from caring for himself in an ordinary manner outside the institution shall be considered to meet patient status. For example, an ambulatory cardiac patient with hypertension may be reasonably stable on appropriate medication, but have intellectual deficiencies preventing safe use of self-medication, or other problems requiring frequent nursing appraisal, and thus be considered to meet patient status; or
- (c) An individual with a stable medical condition manifesting a significant combination of at least two (2) or more of the following care needs shall be determined to meet low-intensity patient status if the professional staff determines that the combination of needs can be met satisfactorily only by provision of intermittent high-intensity nursing care, continuous personal care or supervision in an institutional setting:
 1. Assistance with wheelchair;
 2. Physical or environmental management for confusion and mild agitation;
 3. Must be fed;
 4. Assistance with going to bathroom or using bedpan for elimination;
 5. Old colostomy care;
 6. Indwelling catheter for dry care;
 7. Changes in bed position;
 8. Administration of stabilized dosages of medication;
 9. Restorative and supportive nursing care to maintain the individual and prevent deterioration of his condition;
 10. Administration of injections during time licensed personnel is available;
 11. Services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care; or
 12. Routine administration of medical gases after a regimen of therapy has been established.

An individual may be qualified to receive specialized services for individuals with brain injuries if he/she has a stable medical condition with complicating care needs which prevent the individual from caring for him or herself in an ordinary manner outside an institution; the individual has sufficient neurobehavioral sequelae resulting from the brain injury which, when taken in combination, require specialized services.

The assessment tool used to determine Level Of Care is the MAP 351. The regulations concerning Level of Care are: 907 KAR 1:022, Nursing facility services and intermediate care facility for individuals with mental retardation or a developmental disability services and 907 KAR 3:130, Medical necessity and clinically appropriate determination basis.

The State Law is KRS 205.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- ☐ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ☒ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The tool used for institutional care does not reflect the person's community, home or environmental support systems. The MAP-351 reflects all criteria for Level of Care determination, but also reflects the person-centered supports needed to stay in their home.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Level of Care evaluations are face-to-face evaluations conducted by the independent, conflict-free DMS assessor utilizing the MAP-351 assessment tool, person-centered processes and include the opportunity for the individual to identify other persons to be consulted, such as the individual's spouse, family, guardian and treating and consulting health and support professional responsible for the individual's care. The evaluation will determine the necessary level of care, services and supports needed and desired by the individual; prevent the provision of unnecessary or inappropriate care; and assist with establishing a written person-centered service plan.

The initial evaluation may begin outside of the person's residence, but will be completed within the person's residence. All applicants must have a signed MAP10 KY Physician Recommendation form confirming that Nursing Facility Level of Care is needed. This form must be signed by a Physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant. Once the evaluation is completed, it is reviewed by the QIO. Review by the QIO may be conducted by a Registered Nurse, Social Worker, and/or Physician. If the evaluation meets LOC criteria the individual and the assessor are notified.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- ☐ Every three months
☐ Every six months
☐ Every twelve months
☒ Other schedule

Specify the other schedule:

A minimum of every 12 months and as needed when the individual's support needs or circumstances change significantly.

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- ☒ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
☐ The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

When a person meets the LOC criteria, those dates are entered into the Medicaid Management Information System (MMIS) with a 12 month span. The date begins with the date the MAP-351 is signed. The MAP-351 must be updated at least annually, and annual LOC dates entered into MMIS, in order for authorization to receive services to continue and the provider to receive payment for services provided.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluation and reevaluation documentation is uploaded into the Kentucky Medicaid Waiver Management Application system by the DMS independent assessor where it can be reviewed by the QIO for LOC determination and by other certified service agencies included in the person-centered plan of care.

Kentucky's Medicaid Waiver Management Application will retain these records for a minimum of 6 years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of waiver applicants who had a level of care evaluation. N= Total number of applicants who had a level of care evaluation D= Total number of waiver applicants for whom, based on application information, there is reasonable indication that services may be needed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent, QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Fiscal Agent, QIO	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- b. **Sub-assurance:** The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants who received a redetermination of level of care within 12 months of their initial or last level of care determination. N= Number of LOC determinations with 351 forms on file. D= Number of waiver participants.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- c. **Sub-assurance:** The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of level of care determinations with completed 351 assessment forms on file. N= Number of LOCs with completed 351 forms on file. D=Number of waiver participants.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other	

	Specify:	
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Evaluation and assessment services include a comprehensive initial evaluation and assessment which shall be conducted by the DMS independent assessor within 7 days of receipt of the request. Once a person meets the LOC criteria, those dates are entered into the MMIS with a 12 month span. The date begins with the date the MAP-351 is signed and must be updated in order for continued authorization of services and continued authorization for the provider to receive payment for the provision of services. The state contracts with a fiscal agent who in turn contracts with the QIO for implementation of the LOC process, to ensure that all forms are completed appropriately and accordingly using the 907 KAR 1:022 Nursing Facility Level of Care regulation. The contracts are evaluated and monitored by DMS on a yearly basis to ensure the process is carried out according to DMS rules and regulations.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMS directly addresses problems as discovered through the use of utilization management reports which are generated by the fiscal agent and the QIO for evaluation/reevaluation. These reports show number of new participants who received LOC prior to services being provided, shows number of timely reevaluations, and forms/instruments completed as required by the state. If problems or errors are identified, DMS will meet with the fiscal agent in order to identify and remediate the problem.

ABI LTC members are provided written appeal rights anytime there is an adverse action initiated. These appeals are held timely and fair hearing procedures are exercised through the Administrative Hearings Branch.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal agent, QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All eligible waiver members are informed of their choice of institutional care or waiver programs and available services, including all available waiver service providers by the independent DMS assessor. This information is provided at the initial evaluation and at each reevaluation and documented on the MAP-350, "Long Term Care Facilities and Home and Community Based Program Certification Form". The Map-350 form is uploaded into the KY MWMA system for electronic storage.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The MAP-350 form is uploaded and maintained in the KY Medicaid Waiver Management Application (MWMA). The MWMA system will maintain storage for a minimum of 6 years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

All Kentucky Medicaid providers are required to provide effective language access services to Medicaid members who are limited in their English proficiency (LEP). Specific procedures for assuring LEP access may vary by provider, but are required to address assessment of the language needs of members served by the provider, provision of interpreter services at no cost to the member, and staff training. Provider procedures for assuring LEP access are ensured through routine interaction and monitoring. When the State learns of an individual needing assistance, staff consult with the individual, case manager and the service provider to determine the type of assistance needed and may require additional activities on the part of the provider to ensure the appropriate translation services are available to the individual.

As indicated in Appendix A, Waiver Administration and Operation, of this application, the Department for Medicaid Services (DMS) contracts with several outside entities to perform waiver administrative functions, including level of care determination and prior authorization of services, processing and payment of provider claims and fiscal intermediary services. In addition, the Department for Community Based Services, a governmental unit within the Cabinet for Health and Family Services, determines technical and financial eligibility for Medicaid services. All of these entities are required, through contract, to comply with Federal standards regarding the provision of language services to improve access to their programs and activities for persons who are limited in their English proficiency. Contractors' language services must be consistent with Federal requirements, include a method of identifying LEP individuals, and provide language assistance measures including interpretation and translation, staff training, providing notice to LEP persons, and monitoring compliance and updating procedures.

The Cabinet for Health and Family Services has established a Language Access Section to assist all Cabinet organizational units, including DMS, in effectively communicating with LEP individuals, as well as complying with Federal requirements. The Language Access Section has qualified interpreters on staff, maintains a listing of qualified interpreters for use by CHFS units and contractors throughout the state, contracts with a telephone interpretation service for use by CHFS units and contractors when appropriate, provides translation services for essential program forms and documents, establishes policies and procedures applicable to CHFS, and provides technical assistance to CHFS units as needed. Procedures employed by individual departments and units, including DMS, include posting multi-lingual signs in waiting areas to explain that interpreters will be provided at no cost; using "I Speak" cards or a telephone language identification service to help identify the primary language of LEP individuals at first contact; recording the primary language of each LEP individual served; providing interpretation services at no cost to the individual served; staff training; and monitoring of staff offices and contractors.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Health Care		
Statutory Service	Adult Day Training		
Statutory Service	Conflict-free Case Management		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Behavior Services		
Extended State Plan Service	Counseling		
Extended State Plan Service	Goods and Services		
Extended State Plan Service	Group Counseling		
Extended State Plan Service	Nursing Supports		
Extended State Plan Service	Specialized Medical Equipment		
Supports for Participant Direction	Financial Management Services		
Other Service	Community Living Supports		
Other Service	Environmental and minor home modifications		
Other Service	Family Training		
Other Service	Supervised Residential Care Level I		
Other Service	Supervised Residential Care Level II		
Other Service	Supervised Residential Care Level III		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Adult Day Health ▼

Alternate Service Title (if any):

Adult Day Health Care

HCBS Taxonomy:

Category 1:

04 Day Services ▼

Sub-Category 1:

04060 adult day services (social model) ▼

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Adult day health care (ADHC) services include basic services for waiver members. Basic services include skilled nursing services, one meal per day, snacks, RN supervision, regularly scheduled daily activities, routine personal and healthcare needs and equipment essential to the provision of the ADHC services. ADHC shall be furnished on a regularly scheduled basis. Transportation is not covered under the ADHC element. All ADHC services are prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to 160 units (1 unit equals 15 minutes) per calendar week.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Centers

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Adult Day Health Care****Provider Category:**Agency **Provider Type:**

Adult Day Health Care Centers

Provider Qualifications**License (specify):**

Office of the Inspector General as regulated by 902 KAR 20:066

Certificate (specify):**Other Standard (specify):**

As specified in 907 KAR 1:160 and program regulation 907 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Office of the Inspector General

Frequency of Verification:

Annually or more frequently if necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Day Habilitation ▼

Alternate Service Title (if any):

Adult Day Training

HCBS Taxonomy:

Category 1:

04 Day Services ▼

Sub-Category 1:

04060 adult day services (social model) ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Adult day training services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the residential setting in which the individual resides. Adult day training services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. ADT services stress training in the activities of daily living, self-advocacy, adaptive and social skills and are age and culturally appropriate. The training activities and routines established shall not be diversional in nature but shall be meaningful to the person, shall provide an appropriate level of variation and interest and shall assist the person to achieve personally chosen outcomes which are documented in the Person-Centered Plan of Care. ADT services can be provided at a fixed location, or in community settings. Services provided in a fixed location are typically provided on regularly scheduled basis no more than five days per week. The hours must be spent in training and program activities and must be based on the person's Plan of Care. ADT services lead to the acquisition, improvement and/or retention of skills and abilities to prepare the person for work and/or community access and integration or transition from school to adult responsibilities. In addition, adult day training services may serve to reinforce skills or lessons taught in school, therapy, or other settings. ADT services may be provided as an adjunct to other services included on a person's person-centered plan of care. For example: a person may receive supported employment or other services for part of a day or week and ADT services at a different time of the day or week. ADT services may include work-related training, involvement in community based activities that assist the person in increasing his/her ability to access community resources and being involved with other members of the general population. ADT can be used to provide access to community-based activities that cannot be provided by natural or other unpaid supports and is defined as activities designed to result in increased ability to access community resources without paid supports. All adult day training services must be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 160 15 minute units per week, alone or in combination with Supported Employment Services

Service Delivery Method *(check each that applies):*

- ☒ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- ☒ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers
Individual	Qualified ADT Staff

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Training

Provider Category:

Agency ☐

Provider Type:

Certified waiver providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified at least annually by DMS

Other Standard *(specify):*

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Training

Provider Category:

Individual ☐

Provider Type:

Qualified ADT Staff

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. Is eighteen (18) years or older; and Has a high school diploma or GED; or is at least twenty-one (21) years old; and
2. Meets all applicable personnel and training requirements as stated in ABI regulation;

- 3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.; and
 4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions;
 c) perform required documentation.

All standards as identified in 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

case manager

Frequency of Verification:

Prior to service delivery.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service ▼

Service:

Case Management ▼

Alternate Service Title (if any):

Conflict-free Case Management

HCBS Taxonomy:

Category 1:

01 Case Management ▼

Sub-Category 1:

01010 case management ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
☒ Service is included in approved waiver. The service specifications have been modified.
☐ Service is not included in the approved waiver.

Service Definition (Scope):

Case management involves working with the individual and others that are identified by the individual such as family member (s) in developing a Person Centered Service Plan (PCSP). Case management responsibilities include: coordinating and monitoring chosen services and supports as included in the person-centered service plan, arranging for appropriate natural supports, needed evaluations, and eligibility processes. Case management includes informing the individual of services and supports that are available for participant direction. Using person centered planning processes, case management assists in identifying and implementing support strategies. These strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal and community supports. Case managers will work closely with the individual to assure his or her ongoing expectations and satisfaction with their lives in the community, the processes and outcomes of supports, services, and available resources. Case managers will assure that participants have freedom of choice of providers in a conflict free climate.

Case management involves face-to-face and related contacts to make arrangements for activities which assure the following: The health, safety and welfare of the individual are met, the desires and needs of the individual are determined, the supports and services desired and needed by the individual are identified and implemented; housing and employment issues are addressed, social networks are developed, and appointments and meetings are scheduled. A person-centered approach to planning is provided while utilizing waiver and other community supports. The quality of the supports and services as well as the health and safety of the individuals are monitored. Case manager will assist participant in managing benefits as needed. Activities are documented, and plans for supports and services are reviewed at least annually and more often as needed utilizing person centered planning processes. The CM or designee must be available 24 hours per day.

Case management shall not include direct services. Conflict-free case management requires that a provider, including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider, who renders case management to an individual must not also provide another waiver service to that same individual, unless the provider is the only willing and qualified provider in the geographical area (30 miles from the participant's residence).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to one unit per member, per month, (one unit of service is defined as one calendar month).

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Conflict-free Case Management

Provider Category:

Agency 

Provider Type:

Certified waiver providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified at least annually by DMS.

Other Standard (*specify*):

A registered nurse or an individual who has a Bachelor's degree or higher degree in an approved human services field, from an accredited college or university; or a Bachelors degree in any other field from an accredited college or university with at least 2 years experience working directly with individuals with brain injury.

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually or more frequently if necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Respite care service is defined as short term care which is provided to a waiver recipient due to absence or need for relief of the primary caregiver, or provided to an individual who is unable to care for himself during transition from a residential facility. Respite care services must be provided at a level to appropriately and safely meet the medical needs of the waiver recipient. Respite is considered an essential service to assist the recipient and family to prevent institutionalization. The Case Manager shall be responsible for assisting individuals to access other natural supports or supports available through other available funding streams if their needs exceed the service limit. Respite services shall be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement for respite care services shall be limited to no more than 5760 fifteen minute units (1440 hours) per recipient per calendar year. The limit is based on past maximum historical utilization amounts.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☒ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Qualified Respite Staff
Agency	Adult Day Health Care
Agency	Certified waiver providers
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual 

Provider Type:

Qualified Respite Staff

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- 1.Is eighteen (18) years or older; and Has a high school diploma or GED; or Is at least twenty-one (21) years old; and
- 2.Meets all applicable ABI LTC personnel and training requirements;
- 3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;
- 4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions;c) perform required documentation.

All standards identified in 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Certified provider or case manager

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency 

Provider Type:

Adult Day Health Care

Provider Qualifications

License *(specify):*

902 KAR 20:066

Certificate *(specify):*

Certified, at least annually, by DMS

Other Standard *(specify):*

All standards identified in 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Department for Medicaid Services

Frequency of Verification:

Annually (more frequent if necessary)


Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency 

Provider Type:

Certified waiver providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified, at least annually, by DMS

Other Standard (*specify*):

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency 

Provider Type:

Home Health Agency

Provider Qualifications

License (*specify*):

902 KAR 20:081

Certificate (*specify*):

Certified, at least annually, by DMS

Other Standard (*specify*):

All standards identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service 

Service:

Supported Employment ▼

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

03 Supported Employment ▼

Sub-Category 1:

03010 job development ▼

Category 2:

03 Supported Employment ▼

Sub-Category 2:

03021 ongoing supported employment, individual ▼

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Supported employment services consist of supports needed to assist in gaining and retaining paid employment, at minimum wage or above, for persons who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to obtain and sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 160 fifteen minute units per week, alone or in combination with adult day training services.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☒ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency 

Provider Type:

Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service 

Service Title:

Behavior Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services 

Sub-Category 1:

10040 behavior support 

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Behavior Services is a service to assist the individual with significant, intensive challenges that interfere with activities of daily living, social interaction, work or volunteer situations. These services provide for the utilization of data collected during the functional assessment of behavior: this is the basis for development of a positive behavior support plan for the acquisition or maintenance of skills for community living and behavioral intervention for the reduction of maladaptive behaviors. The plan is intended to be implemented across service settings by individuals assisting the person in meeting their dreams and goals. Intervention modalities described in plans must relate to the identified behavioral needs of the individual, and specific criteria for remediation of the behavior must be established and specified in the plan. The need for the plan shall be evaluated and revisions made as needed and at least annually. It is expected that need for this service will be reduced over time as an individual's skills develop.

These services must be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 80 fifteen minute units per month for the first 3 months of waiver participation, thereafter not to exceed 48 units per month.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers
Agency	Community mental health centers

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Behavior Services

Provider Category:

Agency 

Provider Type:

Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Behavioral services may be provided by a Certified Psychologist with autonomous functioning, Licensed Psychologist, Licensed Psychological Associate, Licensed Psychological Practitioner, Psychiatrist, LCSW, ARNP, Certified Social Worker, Clinical Nurse Specialist with a master's degree in psychiatric nursing, Licensed Professional Clinical Counselor, Licensed Professional Counselor Associate, Licensed Professional Art Therapist, Licensed Professional Art Therapist Associate, Licensed Marriage and Family Therapist, Licensed Marriage and Family Therapist Associate, Medical Doctor, Physician Assistant, Licensed Behavior Analyst, Licensed Assistant Behavior Analyst.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Behavior Services

Provider Category:

Agency 

Provider Type:

Community mental health centers

Provider Qualifications

License (*specify*):

902 KAR 20:091

Certificate (*specify*):



Other Standard (*specify*):

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service 

Service Title:

Counseling

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services 

Sub-Category 1:

10060 counseling 

Category 2:



Sub-Category 2:



Category 3:



Sub-Category 3:



Category 4:



Sub-Category 4:



Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Counseling services are designed to help a member resolve personal issues or interpersonal problems resulting from his or her acquired brain injury and assist a family member in implementing a member's approved assessment of needs and plan of care. May be provided to a family member individually as relates to the psychological services of the waiver participant.

Counseling services must be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 16 units per day.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community mental health centers
Agency	Certified waiver providers

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Counseling

Provider Category:

Agency ☐

Provider Type:

Community mental health centers

Provider Qualifications

License (specify):

902 KAR 20:091

Certificate (specify):

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210.

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Counseling

Provider Category:

Agency ☐

Provider Type:

Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

Counseling may be provided by a Certified Psychologist with autonomous functioning, Licensed Psychologist, Licensed Psychological Associate, Licensed Psychological Practitioner, Psychiatrist, LCSW, ARNP, Certified Social Worker, Clinical Nurse Specialist with a master's degree in psychiatric nursing, Licensed Professional Clinical Counselor, Licensed Professional Counselor Associate, Licensed Professional Art Therapist, Licensed Professional Art Therapist Associate, Licensed Marriage and Family Therapist, Licensed Marriage and Family Therapist Associate, Medical Doctor, Physician Assistant, Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, Certified Alcohol and Drug Counselor, Licensed Alcohol and Drug Counselor, Licensed Alcohol and Drug Counselor Assistant.

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Goods and Services

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

The purchase of goods must be individualized and may be utilized to reduce the need for personal care or enhance the independence within the home or community of the program participant. All items purchased within the individuals budget

must be prior authorized and included in the person-centered plan of care. As a Medicaid funded service this definition will not cover experimental goods and services inclusive of items which may be defined as restrictive under G.S. 122C-60.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individuals shall not receive goods and services through both traditional and participant directed supports. A member may receive a combination of participant directed and traditional waiver services providing duplication of services does not occur. Goods and services shall be prior authorized and payment for these services shall not exceed the member's budget as established by DMS.

Service Delivery Method (*check each that applies*):

- ☒ **Participant-directed as specified in Appendix E**
☐ **Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- ☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Vendor
Individual	Individual Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Goods and Services

Provider Category:

Agency ☐

Provider Type:

Agency Vendor

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must have employees providing services that:

Have an applicable business license for goods or services provided

Understands and agrees to comply with the participant directed services and goods delivery requirements.

All standards identified in 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Manager

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Goods and Services

Provider Category:

Individual ☐

Provider Type:

Individual Vendor

Provider Qualifications**License** *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Have an applicable business license for goods or services provided

Understands and agrees to comply with the self-directed services and goods delivery requirements

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications**Entity Responsible for Verification:**

Case Manager

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Service Title:

Group Counseling

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Group counseling is designed to help a member resolve personal issues or interpersonal problems resulting from his or her acquired brain injury and assist a family member in implementing a member's approved assessment of needs and plan of care. Provided to two to eight members.

Group counseling services must be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Maximum of 48 fifteen minute units per member per month.

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers
Agency	Community mental health centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Group Counseling

Provider Category:

Agency 

Provider Type:

Certified waiver providers

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified, at least annually, by DMS

Other Standard (*specify*):

Counseling may be provided by a Certified Psychologist with autonomous functioning, Licensed Psychologist, Licensed Psychological Associate, Licensed Psychological Practitioner, Psychiatrist, LCSW, ARNP, Certified Social Worker, Clinical Nurse Specialist with a master's degree in psychiatric nursing, Licensed Professional Clinical Counselor, Licensed Professional Counselor Associate, Licensed Professional Art Therapist, Licensed Professional Art Therapist Associate, Licensed Marriage and Family Therapist, Licensed Marriage and Family Therapist Associate, Medical Doctor, Physician Assistant, Licensed Behavior Analyst, Licensed Assistant Behavior Analyst, Certified Alcohol and Drug Counselor, Licensed Alcohol and Drug Counselor, Licensed Alcohol and Drug Counselor Assistant.

All standards identified in 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Group Counseling

Provider Category:

Agency 

Provider Type:

Community mental health centers

Provider Qualifications

License (*specify*):

902 KAR 20:091

Certificate (*specify*):

Other Standard (*specify*):

All standards as identified in 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Service Title:

Nursing Supports

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (*Scope*):

Nursing supports include supports necessary to monitor medication administration, provide training and oversight on specific medication administration including injections, g-tubes, j-tubes, ostomy care, and wound care; or to monitor specific medical conditions for in home care including chemotherapy follow up.

Nursing supports may not be provided in Adult Day Health Centers.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not to exceed 28 fifteen minute units per week.

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Nursing Supports

Provider Category:

Agency 

Provider Type:

Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210 and 907 KAR 7:005

Must be provided by an RN, APRN or LPN.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service 

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

14 Equipment, Technology, and Modifications 

14010 personal emergency response system (PERS) 

Category 2:

Sub-Category 2:

14 Equipment, Technology, and Modifications 14031 equipment and technology

Category 3:

Sub-Category 3:

14 Equipment, Technology, and Modifications 14032 supplies

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, devices which enable individuals at high risk of institutionalization to secure help in an emergency, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

All specialized medical equipment is coordinated and procured by the case manager through various entities which may include, pharmacies, retail stores, medical equipment retailers and other entities. All specialized medical equipment must be prior authorized. Once prior authorized, the cost is submitted to the fiscal agent for payment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Conflict-free Case Management Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Conflict-free Case Management Provider

Provider Qualifications

License (specify):

Certificate (specify):

Certified by Department for Medicaid Services

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department for Medicaid Services

Frequency of Verification:

At least annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Management and direction of funds in the member's approved participant-directed budget. The provider shall perform the employer responsibilities of payroll processing which shall include: issuance of paychecks; withholding federal, state and local tax and making tax payments to the appropriate tax authorities; and, issuance of W-2 forms. The provider shall be responsible for performing all fiscal accounting procedures including issuance of expenditure reports to the member, their representative, the case manager and the Department for Medicaid Services. The provider shall maintain a separate account for each member

while continually tracking and reporting funds, disbursements and the balance of the member's budget. The provider shall process and pay invoices for goods and services approved in the member's plan of care. FMS is required for participants that elect the consumer directed option.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Financial management is defined as a fifteen (15) minute unit. Financial management services are limited to eight (8) units per member, per calendar month. Financial management services are limited to members opting to participant direct some or all of their non-medical services and only apply to participant-directed services.

Service Delivery Method *(check each that applies):*

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by *(check each that applies):*

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Mental Health Center
Agency	Area Development District

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency ☐

Provider Type:

Community Mental Health Center

Provider Qualifications

License *(specify):*

902 KAR 20:091

Licensed by the Office of Inspector General

Certificate *(specify):*

Other Standard *(specify):*

All standards identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency ☐

Provider Type:

Area Development District

Provider Qualifications

License *(specify):*

Certificate (specify):**Other Standard (specify):**

As identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

KY Department for Aging and Independent Living

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Living Supports

HCBS Taxonomy:**Category 1:**

08 Home-Based Services ▼

Sub-Category 1:

08030 personal care ▼

Category 2:

08 Home-Based Services ▼

Sub-Category 2:

08040 companion ▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Community Living Support services facilitate independence and promote integration into the community, for individuals residing in their own home.

Supports are provided one-to-one and include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living such as bathing, eating, dressing, personal hygiene; shopping; money management; reminding, observing and or monitoring of medications; non-medical care not requiring nurse or physician intervention.

These supports also include socialization, relationship building, leisure choice and participation in generic community activities. Supports are based upon therapeutic goals, are not diversional in nature, and are not to replace other work or day activities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Living Supports is limited to 160 fifteen minute units per week. The Case Manager will be responsible for assisting individuals to access other natural supports or supports available through other funding streams if their needs exceed this limit.

Service Delivery Method *(check each that applies):*

- ☒ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- ☒ **Legally Responsible Person**
☒ **Relative**
☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers
Agency	Home Health Agencies
Agency	Community Mental Health Centers
Individual	Qualified CLS Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Living Supports

Provider Category:

Agency 

Provider Type:

Certified waiver providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified, at least annually, by DMS

Other Standard *(specify):*

All standards identified in program regulation 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Living Supports

Provider Category:

Agency 

Provider Type:

Home Health Agencies

Provider Qualifications**License (specify):**

902 KAR 20:081

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Office of Inspector General

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Community Living Supports****Provider Category:**Agency **Provider Type:**

Community Mental Health Centers

Provider Qualifications**License (specify):**

902 KAR 20:091

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Office of Inspector General

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Community Living Supports****Provider Category:**Individual **Provider Type:**

Qualified CLS Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

1.Is eighteen (18) years or older; and has a high school diploma or GED; or is at least twenty-one (21) years old; and

2.Meets all applicable ABI personnel and training requirements as stated in regulation;

3.Has a valid Social Security number or a valid work permit if not a citizen of the U.S.;

4.Has the ability to: a) communicate effectively with the person/family; b) understand and carry out instructions; c) perform required documentation.

All standards identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Case Manager

Frequency of Verification:

Prior to service delivery.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental and minor home modifications

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. All environmental and minor home adaptations shall be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement for environmental and minor home modifications shall be limited to \$2000 per member, per calendar year. The Case Manager shall be responsible for assisting individuals to access other natural supports or supports available through other funding streams if their needs exceed the above limit.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care
Agency	Certified Waiver providers
Agency	Home Health agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental and minor home modifications

Provider Category:

Agency 

Provider Type:

Adult Day Health Care

Provider Qualifications

License (specify):

902 KAR 20:081

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Department for Medicaid Services

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental and minor home modifications

Provider Category:

Agency 

Provider Type:

Certified Waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental and minor home modifications

Provider Category:

Agency

Provider Type:

Home Health agencies

Provider Qualifications

License (specify):

902 KAR 20:066

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 907 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequent if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Family training includes training and counseling services for the families of individuals served on this waiver. Training includes interpretation or explanation of medical examinations and procedures, treatment regimens and use of equipment specified in the plan of care to family or other responsible persons, or advising them how to assist the patient. This service shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

All family training services must be prior authorized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 8 15-minute units per week.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers
Agency	Adult day health care
Agency	Community mental health centers
Agency	Home health agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Family Training

Provider Category:

Agency ☒

Provider Type:

Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

Services are provided by a nurse, LPN or APRN.

For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the participant.

All standards identified in program regulation 907 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Family Training

Provider Category:
 
Provider Type:

Adult day health care

Provider Qualifications**License (specify):**

902 KAR 20:081

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Family Training

Provider Category:
 
Provider Type:

Community mental health centers

Provider Qualifications**License (specify):**

902 KAR 20:091

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Family Training

Provider Category:
 
Provider Type:

Home health agencies

Provider Qualifications**License (specify):**

902 KAR 20:066

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supervised Residential Care Level I

HCBS Taxonomy:**Category 1:**

02 Round-the-Clock Services

Sub-Category 1:

02021 shared living, residential habilitation

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Supervised Residential Care Level I—shall not have greater than three (3) ABI recipients in a home rented or owned by the ABI provider. The service setting must meet all applicable HCBS Final Rule settings requirements. This setting provides up to 24 hr supervision and assistance and training with daily living skills. Supervised Residential Care Level I is targeted for people who require 24 hour intense level of support and are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Supervised Residential Care includes assistance with activities of daily living skills which shall include activities such as ambulation, dressing, grooming, eating, toileting, bathing, meal planning, grocery shopping and meal preparation, laundry, budgeting and financial matters, home care and cleaning, instruction in leisure skills, and instruction in self medication; in addition to social skills training, including the reduction and/or elimination of maladaptive behaviors per the plan of care. Residential services also include protective oversight and supervision, transportation, personal assistance and the provision of medical and health care services that are integral to meeting the daily needs of residents.

Supervised Residential Care Level I may include the provision of up to five (5) unsupervised hours per day per person as identified in the person centered Plan of Care (POC) to promote increased independence which shall be based on the individual needs of a person as determined with the person centered team and reflected in the PCSP. Unsupervised hours are based upon the PCSP developed in the person centered planning process. Those who cannot safely be unsupervised would not be unsupervised. The supports required for each participant will be outlined in their Person Centered Plan which includes a Crisis Prevention Plan.

For each participant approved for any unsupervised time, a safety plan will be created based upon their assessed needs. The Case Manager, as well as other team members, will ensure the participant is able to implement the safety plan. On-going monitoring of the safety plan, procedures or assistive devices required would be conducted by the Case Manager to ensure relevance, ability to implement and functionality of devices if required.

If an individual experiences a change in support needs or status, adjustments in Residential Services shall be made to meet the support needs. Supervised Residential Care shall include the provision or arrangement of transportation to services, activities, and medical appointments as needed; as well as accompanying and assisting an ABI recipient while utilizing transportation services.

Participation in medical appointments and follow-up care as directed by the medical staff.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to one unit per member per calendar day.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers
Agency	Community mental health centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supervised Residential Care Level I

Provider Category:

Agency ☒

Provider Type:

Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supervised Residential Care Level I

Provider Category:

Agency ☐

Provider Type:

Community mental health centers

Provider Qualifications

License (*specify*):

902 KAR 20:091

Certificate (*specify*):

Other Standard (*specify*):

All standards identified in program regulation 97 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ☐

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supervised Residential Care Level II

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services ☐

Sub-Category 1:

02021 shared living, residential habilitation ☐

Category 2:

☐

Sub-Category 2:

☐

Category 3:

☐

Sub-Category 3:

☐

Category 4:

☐

Sub-Category 4:

☐

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.

☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

Supervised Residential Care Level II - shall not have greater than three (3) ABI recipients in a home rented or owned by the ABI provider. Provides 12-18 hours supervision and 24 hour on call support.

The service setting must meet all applicable HCBS Final Rule settings requirements. Supervised Residential Care Level II is targeted for people who require less than 24-hour intense level of support and are individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Supervised Residential Care includes assistance with activities of daily living skills which shall include activities such as ambulation, dressing, grooming, eating, toileting, bathing, meal planning, grocery shopping and meal preparation, laundry, budgeting and financial matters, home care and cleaning, instruction in leisure skills, and instruction in self medication; in addition to social skills training, including the reduction and/or elimination of maladaptive behaviors per the plan of care. Residential services also include protective oversight and supervision, transportation, personal assistance and the provision of medical and health care services that are integral to meeting the daily needs of residents.

Supervised Residential Care Level II provides for up to 6-12 hours of unsupervised hours per day per person as identified in the person centered Plan of Care (POC) to promote increased independence which shall be based on the individual needs of a person as determined with the person centered team and reflected in the PCSP. Unsupervised hours are based upon the PCSP developed in the person centered planning process. The supports required for each participant will be outlined in their Person Centered Plan which includes a Crisis Prevention Plan.

For each participant, during unsupervised time, a safety plan will be created based upon their assessed needs. The Case Manager, as well as other team members, will ensure the participant is able to implement the safety plan. On-going monitoring of the safety plan, procedures or assistive devices required would be conducted by the Case Manager to ensure relevance, ability to implement and functionality of devices if required.

If an individual experiences a change in support needs or status, adjustments in Residential Services shall be made to meet the support needs. Supervised Residential Care shall include the provision or arrangement of transportation to services, activities, and medical appointments as needed; as well as accompanying and assisting an ABI recipient while utilizing transportation services.

Participation in medical appointments and follow-up care as directed by the medical staff.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to one unit per member per calendar day.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified waiver providers
Agency	Community Mental Health Centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supervised Residential Care Level II

Provider Category:

Agency ☒

Provider Type:

Certified waiver providers

Provider Qualifications

License (specify):

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supervised Residential Care Level II

Provider Category:

Agency

Provider Type:

Community Mental Health Centers

Provider Qualifications**License (specify):**

902 KAR 20:091

Certificate (specify):

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210

Verification of Provider Qualifications**Entity Responsible for Verification:**

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supervised Residential Care Level III

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:**Sub-Category 2:**

▼

▼

Category 3:**Sub-Category 3:**

▼

▼

Category 4:**Sub-Category 4:**

▼

▼

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

Supervised Residential Care Level III – (Independent Residential Support) – may be provided in a single family home, duplex or apartment building. No more than two waiver participants may be supported in one home or apartment

Provides support in the home of an ABI participant who lives alone or with an unrelated roommate, as needed with daily living skills which shall include: ambulating, dressing, grooming, eating, toileting, bathing, meal planning, grocery shopping and meal preparation, laundry, budgeting and financial matters, home care and cleaning, instruction in leisure skills, and instruction in self medication. In addition, social skills training including the reduction or elimination of maladaptive behaviors per the plan of care.

Provide or arrange transportation to services, activities, and medical appointments as needed; as well as accompanying and assisting an ABI recipient while utilizing transportation services.

Participation in medical appointments and follow-up care as directed by the medical staff.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to one unit per member per calendar day.

Service Delivery Method (check each that applies):

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by (check each that applies):

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Waiver Providers
Agency	Community Mental Health Centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supervised Residential Care Level III

Provider Category:

Agency ▼

Provider Type:

Certified Waiver Providers

Provider Qualifications

License (specify):

▲
▼

Certificate (specify):

Certified, at least annually, by DMS

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210 and 907 KAR 7:005

Verification of Provider Qualifications

Entity Responsible for Verification:

Department for Medicaid Services

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Supervised Residential Care Level III

Provider Category:

Agency 

Provider Type:

Community Mental Health Centers

Provider Qualifications

License (specify):

902 KAR 20:091

Certificate (specify):

Other Standard (specify):

All standards identified in program regulation 97 KAR 3:210

Verification of Provider Qualifications

Entity Responsible for Verification:

Office of Inspector General

Frequency of Verification:

Annually (more frequently if necessary)

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Conflict-free case management functions are carried out by DMS certified case management providers.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All employees of enrolled waiver providers and employees of members participant directing non-medical waiver services are required to submit to a state criminal background check as directed by 906 KAR 1:190 Kentucky National Background Check. The Kentucky National Background Check system is a secure web-based system that is used to facilitate registry and fingerprint-supported state and national criminal background checks and was established for the purpose of determining whether a provider has been convicted of a crime that bears upon the provider's fitness to have responsibility for the safety and well-being of children, the elderly or individuals with disabilities.

Persons found to have Disqualifying Offenses are prohibited from employment.

(4) "Disqualifying offense" means:

- (a) A conviction of, or a plea of guilty, an Alford plea, or a plea of nolo contendere to:
 - 1. A misdemeanor offense related to abuse, neglect, or exploitation of an adult as defined by KRS 209.020(4) or child, or a sexual offense;
 - 2. A criminal offense against a victim who is a minor, as defined in KRS 17.500;
 - 3. A felony offense involving a child victim;
 - 4. A felony offense under:
 - a. KRS Chapter 209;
 - b. KRS Chapter 218A;
 - c. KRS 507.020;
 - d. KRS 507.030;
 - e. KRS 507.040;
 - f. KRS Chapter 508;
 - g. KRS Chapter 509;
 - h. KRS Chapter 510;
 - i. KRS Chapter 511;
 - j. KRS Chapter 513;
 - k. KRS 514.030;
 - l. KRS Chapter 515;
 - m. KRS 529.100;
 - n. KRS 529.110;
 - o. KRS Chapter 530; and
 - p. KRS Chapter 531;
 - 5. An offense under a criminal statute of the United States or of another state similar to an offense specified in this paragraph; or
 - 6. A crime described in 42 U.S.C. 1320a-7;
- (b) A substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 U.S.C. 1395i-3 or 1396r;
- (c) Registration as a sex offender under federal law or under the law of any state; or
- (d) Being listed on a registry as defined in subsection (9) of this section.

"Registry" means the:

- (a) Nurse aide abuse registry maintained pursuant to 906 KAR 1:100 and 42 C.F.R. 483.156;
- (b) Child abuse and neglect registry maintained pursuant to 922 KAR 1:470 and required by 42 U.S.C. 671(a)(20);
- (c) List of Excluded Individuals and Entities maintained by the United States Department of Health and Human Services, Office of Inspector General pursuant to 42 U.S.C. 1320a-7; and
- (d) Any available abuse registry, including the abuse and neglect registries of another state if an applicant resided in that state.

(9) "State" is defined by KRS 446.010(40).

(10) "Violent crime" means a conviction of, or a plea of guilty, an Alford plea, or a plea of nolo contendere to a capital offense, Class A felony, or Class B felony involving the death of the victim, rape in the first degree or sodomy in the first degree of the victim, sexual abuse in the first degree, or serious physical injury to a victim.

Section 9. Rehabilitation Review. (1)(a) An applicant found on the child abuse and neglect central registry maintained pursuant to 922 KAR 1:470, or found to have a disqualifying offense upon completion of the criminal background check shall be eligible for consideration of rehabilitation under an independent review process.

(b) Consideration of a disqualifying offense under the rehabilitation review process described in this section shall not apply to:

- 1. A disqualifying offense that occurred less than seven (7) years prior to the date of the criminal background check;
- 2. A criminal conviction related to abuse, neglect, or exploitation of an adult or child;
- 3. Registration as a sex offender under federal law or under the law of any state; or

4. A conviction for a violent crime.
- (2) An applicant may submit a written request for a rehabilitation review to the cabinet no later than fourteen (14) calendar days from the date of the notice of the cabinet's determination issued pursuant to Section 7(1) of this administrative regulation regarding a finding on the child abuse and neglect central registry or determination of a disqualifying offense.
- (3) The request for a rehabilitation review shall include the following information:
 - (a) A written explanation of each finding on the child abuse and neglect central registry or each disqualifying offense, including:
 1. A description of the events related to the registry finding or disqualifying offense;
 2. The number of years since the occurrence of the registry finding or disqualifying offense;
 3. The identification of any other individuals involved in the offense;
 4. The age of the offender at the time of the registry finding or disqualifying offense; and
 5. Any other circumstances surrounding the registry finding or offense;
 - (b) Official documentation showing that all fines, including court-imposed fines or restitution, have been paid or documentation showing adherence to a payment schedule, if applicable;
 - (c) The date probation or parole was satisfactorily completed, if applicable; and
 - (d) Employment and character references, including any other evidence demonstrating the ability of the individual to perform the employment responsibilities and duties competently.
- (4) A rehabilitation review shall be conducted by a committee of three (3) employees of the cabinet, each of whom was not responsible for determining:
 - (a) The finding of child abuse or neglect that placed the individual on the central registry; or
 - (b) That the individual has a disqualifying offense.
- (5) The committee shall consider the information required under subsection (3) of this section, and shall also consider mitigating circumstances including:
 - (a) The amount of time that has elapsed since the child abuse and neglect central registry finding or disqualifying offense, which shall not be less than seven (7) years in the case of a disqualifying offense;
 - (b) The lack of a relationship between the registry finding or disqualifying offense and the position for which the individual has applied; and
 - (c) Evidence that the applicant has pursued or achieved rehabilitation with regard to the registry finding or disqualifying offense. The committee shall make a recommendation to the secretary or designee, who shall be responsible for making the final decision.
- (6) The secretary or designee may grant a waiver from the prohibition against employment of an applicant with a child abuse and neglect finding or a disqualifying offense upon consideration of the information required under subsection (3) of this section and the committee's recommendation of subsection (5) of this section.
- (7) No later than thirty (30) calendar days from receipt of the written request for the rehabilitation review, the secretary or designee shall send a written determination on the rehabilitation waiver to the applicant.
- (8) The decision of the secretary or designee pursuant to subsection (7) of this section shall be subject to appeal under KRS Chapter 13B.
- (9) An individual with a finding on the child abuse and neglect central registry or a disqualifying offense shall not be employed by an employer until the employer receives notification from the cabinet that the individual has been granted a waiver.
- (10) An employer is not obligated to employ or offer employment to an individual who is granted a waiver pursuant to this section.

At every annual provider recertification, the Department for Medicaid Services reviews provider personnel files for compliance and the inclusion of this required national background check. Licensed providers are also inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance. Per DMS contractual agreement, The KY Department for Aging and Independent Living (DAIL) monitors the completion of criminal background checks for employees of members who are participant directing their non-medical waiver services.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ☐ **No. The State does not conduct abuse registry screening.**
☒ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All employees of enrolled waiver providers and employees of members participant directing non-medical waiver services are required to submit to a state criminal background check as directed by 906 KAR 1:190 Kentucky National Background Check. The Kentucky National Background Check system is a secure web-based system that is used to facilitate registry and fingerprint-supported state and national criminal background checks and was established for the purpose of determining whether a provider has been convicted of a crime that bears upon the provider's fitness to have responsibility for the safety and well-being of children, the elderly or individuals with disabilities.

Persons found to have Disqualifying Offenses are prohibited from employment.

(4) "Disqualifying offense" means:

- (a) A conviction of, or a plea of guilty, an Alford plea, or a plea of nolo contendere to:
 1. A misdemeanor offense related to abuse, neglect, or exploitation of an adult as defined by KRS 209.020(4) or child, or a sexual offense;
 2. A criminal offense against a victim who is a minor, as defined in KRS 17.500;
 3. A felony offense involving a child victim;
 4. A felony offense under:
 - a. KRS Chapter 209;
 - b. KRS Chapter 218A;
 - c. KRS 507.020;
 - d. KRS 507.030;
 - e. KRS 507.040;
 - f. KRS Chapter 508;
 - g. KRS Chapter 509;
 - h. KRS Chapter 510;
 - i. KRS Chapter 511;
 - j. KRS Chapter 513;
 - k. KRS 514.030;
 - l. KRS Chapter 515;
 - m. KRS 529.100;
 - n. KRS 529.110;
 - o. KRS Chapter 530; and
 - p. KRS Chapter 531;
 5. An offense under a criminal statute of the United States or of another state similar to an offense specified in this paragraph; or
 6. A crime described in 42 U.S.C. 1320a-7;
 - (b) A substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 U.S.C. 1395i-3 or 1396;
 - (c) Registration as a sex offender under federal law or under the law of any state; or
 - (d) Being listed on a registry as defined in subsection (9) of this section.

"Registry" means the:

- (a) Nurse aide abuse registry maintained pursuant to 906 KAR 1:100 and 42 C.F.R. 483.156;
- (b) Child abuse and neglect registry maintained pursuant to 922 KAR 1:470 and required by 42 U.S.C. 671(a)(20);
- (c) List of Excluded Individuals and Entities maintained by the United States Department of Health and Human Services, Office of Inspector General pursuant to 42 U.S.C. 1320a-7; and
- (d) Any available abuse registry, including the abuse and neglect registries of another state if an applicant resided in that state.
- (9) "State" is defined by KRS 446.010(40).
- (10) "Violent crime" means a conviction of, or a plea of guilty, an Alford plea, or a plea of nolo contendere to a capital offense, Class A felony, or Class B felony involving the death of the victim, rape in the first degree or sodomy in the first degree of the victim, sexual abuse in the first degree, or serious physical injury to a victim.

Section 9. Rehabilitation Review. (1)(a) An applicant found on the child abuse and neglect central registry maintained pursuant to 922 KAR 1:470, or found to have a disqualifying offense upon completion of the criminal background check shall be eligible for consideration of rehabilitation under an independent review process.

(b) Consideration of a disqualifying offense under the rehabilitation review process described in this section shall not apply to:

1. A disqualifying offense that occurred less than seven (7) years prior to the date of the criminal background check;
2. A criminal conviction related to abuse, neglect, or exploitation of an adult or child;
3. Registration as a sex offender under federal law or under the law of any state; or
4. A conviction for a violent crime.
- (2) An applicant may submit a written request for a rehabilitation review to the cabinet no later than fourteen (14) calendar days from the date of the notice of the cabinet's determination issued pursuant to Section 7(1) of this administrative regulation regarding a finding on the child abuse and neglect central registry or determination of a disqualifying offense.
- (3) The request for a rehabilitation review shall include the following information:
 - (a) A written explanation of each finding on the child abuse and neglect central registry or each disqualifying offense, including:
 1. A description of the events related to the registry finding or disqualifying offense;
 2. The number of years since the occurrence of the registry finding or disqualifying offense;
 3. The identification of any other individuals involved in the offense;
 4. The age of the offender at the time of the registry finding or disqualifying offense; and

5. Any other circumstances surrounding the registry finding or offense;
 - (b) Official documentation showing that all fines, including court-imposed fines or restitution, have been paid or documentation showing adherence to a payment schedule, if applicable;
 - (c) The date probation or parole was satisfactorily completed, if applicable; and
 - (d) Employment and character references, including any other evidence demonstrating the ability of the individual to perform the employment responsibilities and duties competently.
- (4) A rehabilitation review shall be conducted by a committee of three (3) employees of the cabinet, each of whom was not responsible for determining:
 - (a) The finding of child abuse or neglect that placed the individual on the central registry; or
 - (b) That the individual has a disqualifying offense.
- (5) The committee shall consider the information required under subsection (3) of this section, and shall also consider mitigating circumstances including:
 - (a) The amount of time that has elapsed since the child abuse and neglect central registry finding or disqualifying offense, which shall not be less than seven (7) years in the case of a disqualifying offense;
 - (b) The lack of a relationship between the registry finding or disqualifying offense and the position for which the individual has applied; and
 - (c) Evidence that the applicant has pursued or achieved rehabilitation with regard to the registry finding or disqualifying offense. The committee shall make a recommendation to the secretary or designee, who shall be responsible for making the final decision.
- (6) The secretary or designee may grant a waiver from the prohibition against employment of an applicant with a child abuse and neglect finding or a disqualifying offense upon consideration of the information required under subsection (3) of this section and the committee's recommendation of subsection (5) of this section.
- (7) No later than thirty (30) calendar days from receipt of the written request for the rehabilitation review, the secretary or designee shall send a written determination on the rehabilitation waiver to the applicant.
- (8) The decision of the secretary or designee pursuant to subsection (7) of this section shall be subject to appeal under KRS Chapter 13B.
- (9) An individual with a finding on the child abuse and neglect central registry or a disqualifying offense shall not be employed by an employer until the employer receives notification from the cabinet that the individual has been granted a waiver.
- (10) An employer is not obligated to employ or offer employment to an individual who is granted a waiver pursuant to this section.

At every annual provider recertification, the Department for Medicaid Services reviews provider personnel files for compliance and the inclusion of this required national background check. Licensed providers are also inspected annually by the Office of Inspector General and employee records are reviewed to ensure compliance. Per DMS contractual agreement, The KY Department for Aging and Independent Living (DAIL) monitors the completion of criminal background checks for employees of members who are participant directing their non-medical waiver services.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ☒ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ☐ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*
- ☐ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☒ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Payment for community living supports may be issued to legally responsible individuals for the provision of community living supports, a service similar to personal care, under participant direction. This service is available under traditional waiver services and participant directed services. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant.

In order for a legally responsible individual to provide paid services the services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization. A legally responsible individual may not be approved to provide more than forty (40) hours per week of paid services.

The member chooses a legally responsible individual to provide this service. The member choice is documented in the client file and retained by the Case Manager. Documentation of services provided shall be submitted to the Case manager. The member/representative shall sign the employee's timesheet verifying the accuracy of the time reported. The Case Manager is responsible for monitoring service provision. The Fiscal Intermediary authorizes payment based on the plan of care.

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☐ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☒ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Under no circumstances may a legal guardian or an immediate family member provide traditional waiver services. Immediate family member is defined according to KRS 205.8451 as: a parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, or grandchild. Extended family members that are employed by an ABI LTC provider may provide services.

For participant directed services, the Financial Management Services provider only pays for services specified in the Person Centered Service Plan, and case managers additionally monitor the provision of these services. These services may be participant directed and provided by a friend, family member or other person hired by the participant. A family member living in the home of the waiver recipient may be hired by the participant to provide supports only in specific circumstances including:

- Lack of a qualified provider in remote areas of the state; or
- Lack of a qualified provider who can furnish services at necessary times and places; or
- The family member or guardian has unique abilities necessary to meet the needs of the person; and
- Service must be one that the family member doesn't ordinarily provide.

In addition, in order for a legally responsible individual to provide paid services the following must also apply. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant.

- Services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization.
- A legally responsible individual may not be approved to provide more than forty (40) hours per week of paid services.

If one or more of the above specific circumstances is met for a family member to provide services, the following conditions and situations must also be met:

- Family member must have the skills, abilities, and meet provider qualifications to provide the service;
- Service delivery must be cost effective;
- The use of the family member must be age and developmentally appropriate;

- The use of the family member as a paid provider must enable the person to learn and adapt to different people and form new relationships;
- The participant must be learning skills for increased independence; and
- Having a family member as staff:
 - i. Truly reflects the person's wishes and desires,
 - ii. Increases the person's quality of life in measurable ways,
 - iii. Increases the person's level of independence,
 - iv. Increases the person's choices, and
 - v. Increases access to the amount of service hours for needed supports.

- ☐ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☐ **Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment is continuous and open to any individual or entity. A potential provider may make application by contacting provider enrollment through a toll-free phone number, completing the application process and obtaining an agency license or certification. These provider enrollment forms are also accessible through Internet web access.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of providers with corrective action plans completed within required time frames. N= Number of providers with corrective action plans completed within required time frames. D= Number of providers with corrective action plans.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers who meet certification requirements prior to the provision of waiver services. N=Number of providers who meet certification requirements prior to the provision of waiver services. D= Number of providers

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of providers who continue to meet certification requirements following initial enrollment. N=Number of providers who continue to meet certification requirements following initial enrollment. D= number of providers.

Data Source (Select one):**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval =
		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each

source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new provider agencies that completed mandatory preservice (initial) training. N= Number of new provider agencies that completed mandatory preservice initial training. D= Number of new providers during the reporting period.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: prior to waiver service provision.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percentage of provider agencies whose staff completed mandatory (CEU) annual training. N= Number of provider agencies whose staff completed mandatory (CEU) annual training or they completed following a plan of correction per program regulation requirements. D= Number of provider agencies reviewed during the review period.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state currently verifies that 100% of all ABI LTC waiver providers are qualified, certified and licensed prior to rendering services. Providers who have completed the ABI LTC new provider training or are licensed by OIG are eligible to become Medicaid providers. The States' OIG monitors and re-licenses annually. ABI LTC providers are recertified annually. The state does not contract with non-licensed or non-certified providers. All State policy and procedure updates, additions, and/or changes are communicated through letters and the DMS website.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Discovered problems may require a provider plan of correction. DMS conducts monitoring of Plans of Correction submitted by the provider and provides technical assistance or additional training in response to survey or investigation findings to ensure implementation of the approved plan of correction and compliance with the regulatory requirements. Remediation methods are determined by survey findings and are based on overall volume of deficiencies cited, historical deficiencies from previous surveys or investigations, and analysis of incident management reports. DMS remediation methods may include sanctions, including contingencies with limited timeframes for correction, shortened certification lengths, moratoriums on new admissions and recommendation for termination of provider certification and participation as a provider.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

- ☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Module 1, Attachment #2 for Kentucky's ABI LTC Waiver HCBS Settings Transition Plan for remedial activities related to non compliant settings.

Current processes: When contacted by potential ABI LTC providers, DMS ABI Branch staff discuss HCBS Final Rule requirements and provide verbal and written information describing these requirements ensuring that all potential providers are knowledgeable and aware of HCBS Final Rule requirements to assist the potential provider in making informed choice before proceeding with the provider enrollment and certification process. All physical settings proposed for use by potential ABI LTC waiver providers are visited and inspected by DMS ABI Branch staff to ensure HCBS Final Rule compliance before a setting is certified for use. Those determined as non compliant with HCBS settings rules are not certified for use for the provision of ABI LTC waiver services. Trainings for new and historic providers have been revised to include training on Final Rule requirements, including settings requirements, conflict-free case management requirements and person centered planning requirements. During annual recertification inspections and audits, DMS ABI Branch staff audit providers for compliance with all HCBS Final Rule requirements. Those providers found deficient in any area are required to submit a Plan of Correction with timelines for compliance included. Plans of Correction are monitored by DMS ABI Branch Staff and technical assistance provided to assist with compliance. Those providers with continued non-compliance may be subject to sanctions, up to and including decertification as an ABI LTC provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

MAP 109 "Plan of Care/Prior Authorization for Waiver Services"

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ **Registered nurse, licensed to practice in the State**
☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐ **Licensed physician (M.D. or D.O)**
☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.** *Select one:*

- ☐ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
☒ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The DMS independent assessor will develop the initial plan of care. The DMS independent assessor may not provide other direct services to the participant.

The conflict-free case manager will develop any identified or requested updates or revisions to the POC. Updates or revision are identified through person-centered team meetings or at participant/guardian request. Case management shall be conflict free. Conflict-free case management requires that a provider, including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider, who renders case management to an individual must not also provide another waiver service to that same individual, unless the provider is the only willing and qualified provider in the geographical area (30 miles from the participant's residence).

For recipients who request an exception to this based on lack of qualified or willing case managers in remote areas of the state DMS will ensure, on an individual basis, that persons who request a conflict-free exemption will be free from undue influence regarding choice of providers. To request an exemption from conflict-free case management requirements for geographical reasons, a person, assisted by the DMS independent assessor if needed, will submit to DMS a MAP-531 Conflict Free Exemption request form. Submission of the MAP-531 form requires the attachment of documented evidence confirming there is no other or willing conflict-free case management provider within 30 miles of the participant's residence, including provider denials of service, if applicable. Upon receipt, DMS will review the request and verify that the submitted evidence accounts for any case management providers within 30 miles of the participant's residence. DMS will then approve or deny the request.

If an exemption is approved, the case management agency shall document conflict of interest protections, separating case management and service provision functions within the provider entity. Individuals must be provided with a clear and accessible alternative dispute resolution process.

Exemptions, or continued exemptions, from conflict free case management requirements shall be requested upon reassessment or at least annually.

DMS ABI Branch program staff conduct provider billing and service reviews to assure that provided services meet regulatory requirements, are provided as identified in the person centered service plan, and are delivered by qualified staff.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Person-centered Service Plan Requirements. (1) A person-centered service plan shall be established:

- (a) For each participant; and
 - (b) By the participant's person-centered service plan team.
- (2) A participant's person-centered service plan shall:
- (a) Be developed by:
 - 1. The participant, the participant's guardian, or the participant's representative;
 - 2. The participant's case manager;
 - 3. The participant's person-centered team; and
 - 4. Any other individual chosen by the participant if the participant chooses any other individual to participate in developing the person-centered service plan;
 - (b) Use a process that:
 - 1. Provides the necessary information and support to empower the participant, the participant's guardian, or participant's legal representative to direct the planning process in a way that empowers the participant to have the freedom and support to control the participant's schedules and activities without coercion or restraint;
 - 2. Is timely and occurs at times and locations convenient for the participant;
 - 3. Reflects cultural considerations of the participant;
 - 4. Provides information:
 - a. Using plain language in accordance with 42 C.F.R. 435.905(b); and
 - b. In a way that is accessible to an individual with a disability or who has limited English proficiency;
 - 5. Offers an informed choice defined as a choice from options based on accurate and thorough knowledge and understanding to the participant regarding the services and supports to be received and from whom;
 - 6. Includes a method for the participant to request updates to the person-centered service plan as needed;
 - 7. Enables all parties to understand how the participant:
 - a. Learns;
 - b. Makes decisions; and
 - c. Chooses to live and work in the participant's community;
 - 8. Discovers the participant's needs, likes, and dislikes;
 - 9. Empowers the participant's person-centered team to create a person-centered service plan that:
 - a. Is based on the participant's:

- (i) Assessed clinical and support needs;
- (ii) Strengths;
- (iii) Preferences; and
- (iv) Ideas;
- b. Encourages and supports the participant's:
 - (i) Rehabilitative needs;
 - (ii) Habilitative needs; and
 - (iii) Long term satisfaction;
- c. Is based on reasonable costs given the participant's support needs;
- d. Includes:
 - (i) The participant's goals;
 - (ii) The participant's desired outcomes; and
 - (iii) Matters important to the participant;
- e. Includes a range of supports including funded, community, and natural supports that shall assist the participant in achieving identified goals;
- f. Includes:
 - (i) Information necessary to support the participant during times of crisis; and
 - (ii) Risk factors and measures in place to prevent crises from occurring;
- g. Assists the participant in making informed choices by facilitating knowledge of and access to services and supports;
- h. Records the alternative home and community-based settings that were considered by the participant;
- i. Reflects that the setting in which the participant resides was chosen by the participant;
- j. Is understandable to the participant and to the individuals who are important in supporting the participant;
- k. Identifies the individual or entity responsible for monitoring the person-centered service plan;
- l. Is finalized and agreed to with the informed consent of the participant or participant's legal representative in writing with signatures by each individual who will be involved in implementing the person-centered service plan;
- m. Shall be distributed to the individual and other people involved in implementing the person-centered service plan;
- n. Includes those services which the individual elects to self-direct; and
- o. Prevents the provision of unnecessary or inappropriate services and supports; and
- (c) Includes in all settings the ability for the participant to:
 - 1. Have access to make private phone calls, texts, or emails at the participant's preference or convenience; and
 - 2.a. Choose when and what to eat;
 - b. Have access to food at any time;
 - c. Choose with whom to eat or whether to eat alone; and
 - d. Choose appropriating clothing according to the:

- (i) Participant's preference;
- (ii) Weather; and
- (iii) Activities to be performed.

(3) If a participant's person-centered service plan includes ADHC services, the ADHC services plan of treatment shall be addressed in the person-centered service plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The participant's Person Centered Service Plan (PCSP) is developed utilizing the MAP-351 comprehensive assessment tool. The MAP-351 includes information about the member's support needs in the areas of home living, community living, learning, employment, health and safety, advocacy, behavioral, and medical needs. DMS independent program assessors are trained to conduct MAP-351 assessments and to ensure inclusion of the person, guardian, family members and others identified by the person for inclusion in the assessment process. The MAP-351 includes assessment of overall health risks related to disability and aging, and provides the case manager and support team with guidance in determining the person's need for further assessment and evaluation to address identified health risks.

The PCSP shall include all identified needs (from the assessment) as well as identify goals, objectives/interventions and outcomes. The PCSP is developed at the direction of the member and/or guardian as well as their identified circle of support. All individuals participating in the development of the PCSP must sign the document to indicate their involvement. It is the responsibility of the case manager to provide detailed information to the person centered team regarding available waiver and non-waiver services and providers to meet the identified needs. The member is free to choose from the listing of available waiver providers as well as identified services. The PCSP shall include all needed services and supports both paid and non-paid, waiver and non-waiver.

All PCSP's are reviewed and requested services prior authorized through the QIO entity contracted by Medicaid through the fiscal agent. When PCSP's are submitted, a summary of the completed assessment is included in the packet. the QIO is responsible for review of the assessment summary ensuring all identified needs are included and adequately addressed in the PCSP. If through the prior authorization process, it is determined that identified needs are not addressed in the PCSP, The QIO will issue written notification to the case manager requiring additional information as to how these needs will be addressed.

The participant's case manager is responsible for the coordination and monitoring all of the participant's services including non-waiver services. The case manager shall conduct monthly face-to-face contacts to make arrangements for activities which ensure: the desires and needs of individual are determined; the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are coordinated; activities are documented; and plans of supports/services are reviewed at least annually and at such intervals as are indicated during person-centered planning.

The PCSP shall be updated at least every twelve (12) months and as often as necessary to address changes in the member's needs. Any changes in the member's needs shall be identified by the case manager during the monthly face-to-face contact. All PCSP requirements are contained in the state regulation 907 KAR 3:210 governing the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the member are identified during completion of the comprehensive MAP-351 assessment and during the person-centered team meeting process. All health, safety and welfare risks are required to be identified and addressed in the person-

centered planning meeting and on the PCSP. Providers are required to have agency emergency plans and person specific crisis and safety assurances incorporated into their policies and procedures.

The QIO reviews the submitted MAP351 assessments during the prior authorization process, plan of care review, to ensure all identified risks are appropriately addressed. If QIO determines an identified risk has not been addressed in the PCSP, they will issue written notification to the case manager requiring additional information as to how these risks will be addressed. Additional review is conducted by DMS ABI Branch Staff during on-site audits and inspections. If DMS ABI Branch staff identify a risk or potential risk has not been identified, notification is given to the case manager and additional information will be required as to how the identified risk will be addressed. Identified risks shall also be included in the Crisis and Safety plan based on the participant's needs and preferences as identified through the person-centered planning process

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The case manager is responsible for providing information to the person on all available waiver service providers to ensure informed choice of providers. All persons are ensured freedom of choice when choosing waiver service providers. Freedom of choice is confirmed by the person's or guardian's signature on the MAP 350 form which is required to be maintained within the member's chart. The case manager are responsible for assisting the member in choosing his or her providers of services specified in the POC and arranging for the members, families or guardians to visit waiver providers. This assistance may include telephonic or on-site visits with members and their families, providing the certified provider list or assistance with accessing the electronic provider listing, answering questions about providers, and informing them of web-based provider profiles. DMS will ensure on an individual basis that persons who choose not to have a conflict-free case manager will be free from undue influence regarding choice of providers.

All waiver participants are ensured freedom of choice as defined by the experience of independence, individual initiative, or autonomy in making life choices, both in small everyday matters (what to eat or what to wear), and in large, life-defining matters (where and with whom to live and work);

The service, provider and setting are selected by the individual from among setting options including non-disability specific settings;

The individual must be provided with the choice of where to live with as much independence as possible, and in the most community-integrated environment;

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs and preferences, and, for residential settings, resources available for room and board.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Upon the case manager's completion of the Person Centered Service Plan (PCSP) it is the responsibility of the case manager to enter the PCSP into the Medicaid Waiver Management Application (MWM) for QIO review and service prior authorization. A prior authorization shall not be issued without appropriate review and approval.

Medicaid contracts with a QIO to review and prior authorize all services plans. DMS meets regularly with the QIO to review a sample of plans and discuss any issues that have been identified.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☐ Every twelve months or more frequently when necessary
- ☒ Other schedule

Specify the other schedule:

A minimum of every 12 months and as needed when the individual's support needs or circumstances change significantly.

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- ☐ Medicaid agency
☐ Operating agency
☐ Case manager
☒ Other

Specify:

Service plan forms are required to be entered by the case manager into the KY Medicaid Waiver Management Application (MWMA) and are maintained by the MWMA system for a minimum of 6 years.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The member's conflict-free case manager is responsible for the coordination and monitoring of all of the member's person-centered services including non-waiver services. The case manager shall conduct monthly face-to-face contacts and coordinate person-centered team meetings at convenient times and

locations for the participant to identify and make arrangements for activities which ensure: the desires and needs of the individual are determined; the supports and services desired and needed by the member are identified and implemented; housing and employment issues are addressed; social networks are developed; appointments and meetings are scheduled; a person-centered approach to planning is provided; informal and community supports are utilized; the quality of the supports and services as well as the health and safety of the individual are monitored; income/benefits are maximized based on need; activities are documented; and plans for supports/services are reviewed at such intervals as are indicated during the person-centered planning process.

- b. **Monitoring Safeguards.** *Select one:*

- ☐ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
☒ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.
Specify:

Case management shall be conflict free. Conflict-free case management requires that a provider, including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider, who renders case management to an individual must not also provide another waiver service to that same individual, unless the provider is the only willing and qualified provider in the geographical area (30 miles from the participant's residence).

For recipients who request an exception to this based on lack of qualified or willing case managers in remote areas of the state DMS will ensure, on an individual basis, that persons who request a conflict-free exemption will be free from undue influence regarding choice of providers. To request an exemption from conflict-free case management requirements for geographical reasons, a person, assisted by their case manager if needed, will submit to DMS a MAP-531 Conflict Free Exemption request form. Submission of the MAP-531 form requires the attachment of documented evidence confirming there is no other or willing conflict-free case management provider within 30 miles of the participant's residence, including provider denials of service, if applicable. Upon receipt, DMS will review the request and verify that the submitted evidence accounts for any case management providers within 30 miles of the participant's residence. DMS will then approve or deny the request.

If an exemption is approved, the case management agency shall document conflict of interest protections, separating case management and service provision functions within the provider entity. Individuals must be provided with a clear and accessible alternative dispute resolution process.

Exemptions, or continued exemptions, from conflict free case management requirements shall be requested upon reassessment or at least annually.

DMS ABI Branch program staff conduct provider billing and service reviews to assure that provided services meet regulatory requirements, are provided as identified in the person centered service plan, and are delivered by qualified staff.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment(s).

N=Number of participants reviewed who had service plans that were adequate and appropriate to their needs. D=Number of participants reviewed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of initial service plans that received prior authorization from the QIO prior to service delivery. N= Number of initial service plans that received prior authorization from the QIO prior to service delivery. D= Number of initial service plans that received prior authorization.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

Number and percent of updated service plans submitted following the person-centered team meeting held within the first 30 days of initial service authorization. N= Number of updated service plans submitted within the first 30 days of initial service authorization. D= Number of updated initial service plans submitted.

Data Source (Select one):**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

Number and percent of participants receiving participant-directed services with an approved budget. N= Number of participants receiving participant directed services with an approved budget. D= Number of participants receiving participant-directed services.

Data Source (Select one):**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose service plans were updated and submitted prior to the annual recertification date. N= Number of waiver participants whose service plans were updated and submitted prior to the annual recertification date. D= Number of participants whose service plans were updated and submitted.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
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<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants who received services in the type, scope, amount and duration as specified in the service plan. N= Number of participants who received services in the type,scope, amount and duration as specified in the service plan. D= Number of participants who received services.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
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		<input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participants who received participant directed services within the approved budget. N= Number of participants who received participant directed services within the approved budget. D= Number of participants who received participant directed services.

Data Source (Select one):**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
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	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver participants whose records contain confirmation of notification of the option to choose participant directed services. N= Number of waiver participants whose records contain confirmation of notification of the option to choose consumer directed options. D= Number of waiver participants.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: QIO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div> <div></div> <div></div> </div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div> <div></div> <div></div> </div>
	<input type="checkbox"/> Other Specify: <div> <div></div> <div></div> </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div> <div></div> <div></div> </div>

Performance Measure:

Number and percent of waiver participant records with an appropriately completed and signed freedom of choice form specifying choice was offered between waiver services and institutional care, waiver services and waiver providers. N= Number of participant records with an appropriately completed and signed freedom of choice form. D= Number of participant records.

Data Source (Select one):**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div> <div></div> <div></div> </div>
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: QIO		Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. If the QIO determines an identified risk noted on the assessment has not been addressed on the PCSP, the QIO will issue written notification to the provider requiring additional information as to how these risks will be addressed. DMS performs an annual monitoring of a random sample of enrolled active ABI waiver providers. Monitoring the PCSP includes ensuring all needs are met by appropriate interventions with specific goals and outcomes. If services are not appropriate, DMS will request in the report that a corrective action plan is required. The enrolled provider submits the corrective action plan with supporting evidence of the implementation and remediation. A follow-up survey/review will be performed after DMS' acceptance of the provider's corrective action plan to determine whether it has been implemented.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Identified individual problems are researched and addressed by DMS staff. This may involve DMS staff conducting an on-site agency review, and/or a home visit with the waiver member and caregivers. Issues may require policy clarification. The State receives a utilization management report showing the number of service plans received, the number returned for lack of information, the number of service plans corrected and returned in a timely manner, the number not turned in timely and the responsible provider. DMS is able to request corrective action plans and recoupment of paid claims from the provider. DMS is able to request corrective action plans from the QIO if a service plan is approved, but does not meet requirements.

DMS monitors appropriateness and implementation of the PCSP; and monitors documentation to ensure the member has been fully educated regarding options available and assisted to have freedom of choice and decision making authority. The monitoring occurs through review of the member's clinical record during provider certification surveys conducted at least annually.

All members are informed of their rights and responsibilities at the time of initial assessment and annual reassessment. This information is documented and maintained by the waiver provider in the member clinical record. This information is

reviewed at least annually by DMS or designee during certification surveys and also reviewed during investigations related to this area. DMS also monitors on site during reviews.

ABI LTC members are provided written appeal rights anytime there is an adverse action initiated. These appeals are held timely and fair hearing procedures are exercised through the Administrative Hearings Branch. DMS tracks and trends all appeals to identify criteria or regulatory language requiring modification.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

☐ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

☒ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The ABI LTC waiver program promotes personal choice and control over the delivery of waiver services by affording opportunities for participant direction. ABI LTC participants have the opportunity to direct some or all of their non-residential, non-medical

waiver services. Traditional service delivery methods are available for participants who decide not to direct their services. Case managers provide assistance for informed decision-making by individuals and their families/representatives about the election of participant direction with information and training on the roles, risks, and responsibilities assumed by those who choose participant direction. The following entities will provide supports to participants choosing to direct their own services:

- Case Management agencies will be independent of service delivery. Case Managers will assist with the development of a person centered team and service plan.
- Financial Management Services agency will manage the budget, ensure wage and hour laws are met, and issue checks for services authorized in the Service Plan.
- Participants can choose agencies who will train and support qualified staff for services of the person's choosing.
- Participants can hire their own employees that meet qualifications.

Kentucky's participant-directed option is based on the principles of Self-Determination and Person Centered thinking. A person-centered system acknowledges the role of families or guardians in planning for persons who need assistance in making informed choices. The principles and tools of Self-Determination are used to assist people in the creation of meaningful, culturally appropriate lives which includes real relationships and inclusion in their communities.

Supports that facilitate independence include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation; laundry; routine household care and maintenance; activities of daily living as such as bathing, eating, dressing, personal hygiene, shopping and the use of money; reminding, observing, and/or monitoring of medications; respite; socialization, relationship building, leisure choice and participation in generic community activities.

For participant directed services, the Financial Management Services provider only pays for services specified in the Individual Service Plan, and case managers additionally monitor the provision of these services. These services may be participant directed and provided by a friend, family member or other person hired by the participant. A family member living in the home of the waiver recipient may be hired by the participant to provide supports only in specific circumstances including:

- Lack of a qualified provider in remote areas of the state; or
- Lack of a qualified provider who can furnish services at necessary times and places; or
- The family member or guardian has unique abilities necessary to meet the needs of the person; and
- Service must be one that the family member doesn't ordinarily provide.

In addition, in order for a legally responsible individual to provide paid services the following must also apply. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological, adoptive, foster or step) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant.

- Services must be extraordinary, exceeding the range of activities that a legally responsible individual would ordinarily provide in the household on behalf of a person without a disability of the same age, and which are necessary to assure health and welfare of the person and avoid institutionalization.
- A legally responsible individual shall not be approved to provide more than forty (40) hours per week of paid services.

If one or more of the above specific circumstances is met for a family member to provide services, the following conditions and situations must also be met:

- Family member must have the skills, abilities, and meet provider qualifications to provide the service;
- Service delivery must be cost effective;
- The use of the family member must be age and developmentally appropriate;
- The use of the family member as a paid provider must enable the person to learn and adapt to different people, form new relationships and support community access;
- The participant must be learning skills for increased independence; and
- Having a family member as staff:
 - i. Truly reflects the person's wishes and desires,
 - ii. Increases the person's quality of life in measurable ways,
 - iii. Increases the person's level of independence,
 - iv. Increases the person's choices, and
 - v. Increases access to the amount of service hours for needed supports.

All participants are afforded the opportunity to direct non-residential, non-medical waiver services as long as provider qualifications and background checks as defined in waiver regulations are met. A member may receive a combination of participant directed and traditional waiver services. Services shall be prior authorized and payment for these services shall not exceed the member's budget as established by the Medicaid contracted entity.

The independent assessor and case manager are responsible for educating participants regarding participant directed opportunities. Independent Assessor or Case manager meets with participants to detail the participant directed service options; develop the Person Centered Service Plan to include participant directed services; establish the budget allowance; and, assist the member with any other question they may have regarding participant direction.

A monthly face-to-face contact is required between the case manager and the participant and representative (if applicable) to ensure the needs are being met in an appropriate manner and monitor health, safety and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

- ☐ **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ☐ **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ☒ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- ☒ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
- ☐ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- ☐ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- ☐ Waiver is designed to support only individuals who want to direct their services.
- ☒ The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- ☐ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The DMS Independent Assessor provides information to the participant during the completion of the MAP351 assessment process. The confirmation of provided participant direction information and the choice to participate in, or decline the opportunity to participant direct waiver services is documented on the MAP 351 assessment.

The Independent Assessor provides information to the participant related to their choice to direct their own non medical waiver

services, the responsibilities of the participant when choosing to direct these services, and any possible associated liabilities. The case managers will be required to provide information about participant direction opportunities to the participants during the person-centered team meetings and at any time of recipient or guardian inquiry. Case managers will complete the person centered Plan of Care, and provide detailed information regarding the participant direction opportunities available through the waiver program. The DMS Independent Assessor and case manager will be responsible for explaining the recipient's responsibilities related to participant direction opportunities.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ The State does not provide for the direction of waiver services by a representative.
- ☒ The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- ☒ Waiver services may be directed by a legal representative of the participant.
- ☒ Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A non-legal representative may be freely chosen by an adult waiver recipient to direct waiver services. This representative may not be hired as an employee to provide any of the participant-directed waiver services. The Representative shall act in accordance with the needs and preferences of the participant, as documented in the person centered planning process. The representative must undergo the same background check as identified for employees. The representative must adhere to the person centered principles of the waiver and fulfill the responsibilities as a PDS employer. The representative must also undergo training on fraud, abuse, neglect, and exploitation. The representative must also sign the Rights, Risks, and Responsibilities form yearly. This form explains the rights and responsibilities of the waiver program and the consequences, which may include termination from the program, if they are not followed. The case manager is responsible for monitoring the member's person-centered service plan, ensuring needed services are being appropriately provided to the member and that the member remains satisfied with the services provided. If services are not being provided in accordance with the plan, or if the case manager has concerns that the representative is not operating in the best interest of the participant, the case manager shall work with the member and representative to create a corrective action plan. If the issues continue, or the participant's health, safety and welfare are at risk, the case manager shall transition the participant to traditional services and a 10 day notice to a fair hearing will be provided.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Day Training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Goods and Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Community Living Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- ☒ Yes. Financial Management Services are furnished through a third party entity. (*Complete item E-1-i*).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- ☒ **Governmental entities**
☒ **Private entities**
☐ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.**

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- ☒ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Services

- ☐ **FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Financial management services (FMS) are provided through an inter-agency contract with the Department for Aging and Independent Living (DAIL). DAIL subcontracts with the regional Community Mental Health Centers and Area Development Districts to provide FMS to members utilizing participant directed opportunities. Community Mental Health Centers are quasi-governmental agencies that provide a comprehensive range of accessible and coordinated mental health services, including direct or indirect mental health through Kentucky's 14 regional MH/MR boards. Regional Boards are private, non-profit organizations established to serve residents of a designated multicounty region.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

DMS compensates Financial Management Service providers based on a specified rate for a 15 minute unit of service not to exceed \$100.00 per month, per member.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☐ **Assist participant in verifying support worker citizenship status**
☒ **Collect and process timesheets of support workers**
☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
☒ **Track and report participant funds, disbursements and the balance of participant funds**
☒ **Process and pay invoices for goods and services approved in the service plan**
☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- ☐ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- ☒ Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

All financial management services (FMS) entities are subject to an annual on-site review by the Department for Aging and Independent. This review shall include audits of submitted timesheets and supporting documentation against any payments issued to employees by the FMS. The audit shall identify any deficiencies and require a corrective action plan from the FMS. Member satisfaction surveys shall be conducted annually (at a minimum) and those survey results will be utilized to address and resolve FMS issues.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

At the time of independent assessment, the independent assessor informs the person of participant directed opportunities available, provides an overview of services and responsibilities and confirms the interest of the person in these opportunities. If the person confirms their desire to participant direct services, the chosen conflict-free Case manager will meet with the member to detail the participant directed service options; develop the Plan of Care to include participant directed services; establish the member's budget allowance; and, assist the member with any other question they may have regarding participant direction.

A monthly face-to-face contact is required between the case manager and the member and member's representative (if applicable) to ensure the member's needs are being met in an appropriate manner and to monitor health, safety and welfare.

- ☒ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Conflict-free Case Management	<input checked="" type="checkbox"/>
Nursing Supports	<input type="checkbox"/>
Environmental and minor home modifications	<input type="checkbox"/>
Counseling	<input type="checkbox"/>
Supervised Residential Care Level III	<input type="checkbox"/>
Behavior Services	<input type="checkbox"/>
Supervised Residential Care Level I	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Supervised Residential Care Level II	<input type="checkbox"/>

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Adult Day Training	<input type="checkbox"/>
Goods and Services	<input type="checkbox"/>
Adult Day Health Care	<input type="checkbox"/>
Community Living Supports	<input type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>
Group Counseling	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>

- ☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- ☒ **No. Arrangements have not been made for independent advocacy.**
- ☐ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. **Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A member may voluntarily disenroll from the participant direction opportunities at any time and for any reason. The case manager shall begin to assist the member and/or guardian within one (1) business day of the voluntary termination request to locate traditional waiver service providers of their choice. The case manager will continue working with the member and/or guardian and current employees until a traditional provider is located and services are transitioned to ensure there is no gap in service provision.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Participants may be involuntarily transitioned to traditional services for the following reasons:

1) Health, Safety and Welfare of the Participant. If the case manager determines that the participant is in immediate danger, an employee or representative has exhibited abusive, intimidating or threatening behavior or the health, safety and welfare of the participant is at risk, the case manager will immediately assist the participant in transferring to a qualified traditional waiver

provider of the participant's choice. In addition, the case manager shall immediately notify appropriate agencies and authorities regarding any suspected abuse, safety or neglect allegations.

2) Safety of Provider. If the participant, employee or representative has exhibited abusive, intimidating or threatening behavior toward provider staff, the case manager will work with the participant or the designated representative to discuss the issue and develop a corrective action plan. The case manager will monitor the progress of the corrective action plan. If the participant is unable or unwilling to resolve the issue, the case manager will request to proceed with involuntary transition from the PDS option. This request is made to the Department for Aging and Independent Living (DAIL) as the contracted entity for oversight, implementation and monitoring of participant directed services. The case manager will provide the participant with written information regarding the traditional program and available traditional providers and will assist the participant in obtaining a traditional provider. The participant will be provided written notice of a fair hearing 10 days prior to the transition. If the Participant requests an administrative level hearing within 10 days of the termination letter, services will continue under PDS until a decision is rendered. The case manager shall document the reason for the transition, actions taken to assist the member to develop a corrective action plan and the outcomes. If a service provider believes the environment is not safe for employees, the provider may choose to notify the case manager of their intent to cease services immediately. Every effort will be made to find another provider either for PDS or traditional. If no willing provider is found, the participant will be provided with notice of a fair hearing. In addition, the case manager shall immediately notify appropriate agencies and authorities regarding safety or neglect risks.

3) Failure to Follow Service Plan or Act as an Employer. If monitoring activities reflect the participant's needs are not being met in accordance with the approved person centered service plan and/or the funds in the individualized budget are not being utilized according to program criteria and/or the participant or representative fail to fulfill the duties of their requirements as an employer, the case manager will work with the participant or the designated representative to resolve the issues and develop a corrective action plan. The case manager will monitor the progress of the corrective action plan and resulting outcomes. If the member is unable to resolve the issue, or unable to develop and implement a corrective action plan within sixty (60) days of identification of the issue, the case manager will request approval from DAIL to proceed with transition to traditional services from the PDS option. If approved, the case manager will provide the participant with written information regarding the traditional program and available providers. The case manager shall document the reason for the PDS option withdrawal, actions taken to assist the member to develop a corrective action plan and the outcomes. The case manager shall assist the member and/or guardian in locating traditional waiver service providers of their choice. The case manager will continue working with the member and/or guardian and current employees until a traditional provider is located and services are started. The participant will be provided with a fair hearing notice 10 days prior to transition. Services will continue until a decision is rendered. If the participant has been terminated from a traditional service provider due to any of the above listed behaviors, the participant shall not be approved to be served under the participant directed services option.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants	Number of Participants	
Year 1	<input type="text"/>	50	<input type="text"/>
Year 2	<input type="text"/>	60	<input type="text"/>
Year 3	<input type="text"/>	65	<input type="text"/>
Year 4	<input type="text"/>	70	<input type="text"/>
Year 5	<input type="text"/>	75	<input type="text"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- ☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

-
- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☒ **Hire staff common law employer**
☒ **Verify staff qualifications**
☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The participant, or their designee, is responsible for the cost of obtaining criminal background checks, drug testing and all cost associated with training

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☒ **Determine staff wages and benefits subject to State limits**
☒ **Schedule staff**
☒ **Orient and instruct staff in duties**
☒ **Supervise staff**
☒ **Evaluate staff performance**
☒ **Verify time worked by staff and approve time sheets**
☒ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☐ **Reallocate funds among services included in the budget**
☒ **Determine the amount paid for services within the State's established limits**
☒ **Substitute service providers**
☒ **Schedule the provision of services**
☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
☒ **Identify service providers and refer for provider enrollment**
☐ **Authorize payment for waiver goods and services**
☐ **Review and approve provider invoices for services rendered**
☐ **Other**

Specify:




Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The QIO shall establish an individualized budget based on needs as identified in the MAP351 assessment and the prior authorized services in the person-centered service plan. The budget can be adjusted as needs change. The participant may negotiate wage rates with employees however the hourly rate shall not exceed the rate reimbursed to traditional waiver providers for a similar service.

Budgets are provided to the member based on the requested hours defined by regulation and justified by the plan of care submitted by the member/providing agency. The additional factors are determined by each member that submits a budget. 907 KAR 3:210 governs how many units can be requested and can be located on the Medicaid webpage.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The independent assessor will inform the participant and the team of the estimated budget based on the unit rate set by the participant, amount of services requested and estimated taxes for the area.

At any time, if a participant's needs change, the participant/representative may request the conflict-free case manager to submit a request to modify the service plan. The budget is based strictly on the approved services based on the needs as identified in the assessment. Any increase in services which will impact the budget must be based on changes in the participant's circumstances. If a change has occurred, the case manager will request a new assessment. Once a new assessment has been completed the case manager will set up a person-centered team meeting to create a new service plan. The plan will be submitted to the QIO for approval and, if approved, the changes in service/budget will become effective. In cases of an emergency, such as coming home from the hospital, the case manager can submit a modification for approval by the QIO without a new assessment. A person centered team meeting to review the modified plan must be scheduled within 30 days of approval of the emergency modification.

If a request for service modification is denied, the participant will be provided with information regarding the fair hearing process. The fair hearing information will be included in the denial letter.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- ☒ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ☐ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:




Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The case manager and financial management services (FMS) entity shall continually monitor expenditures for each member. Monthly reports shall be provided to the operating agency and the Department for Medicaid Services (DMS) outlining member budget activity. Should a member be identified as prematurely depleting their budget, the case manager shall contact the member and/or representative and conduct a face-to-face visit to discuss this issue. The case manager shall assist the member and/or representative in development and implementation of a corrective action plan to avoid complete depletion of the established budget prior to allocation of the next budget. The member and/or representative and case manager shall monitor the progress of achieving the goals outlined in the corrective action plan as often as necessary to obtain compliance. It is the responsibility of the case manager to ensure the member is made aware of the implications of underutilization of their budgets.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals who are denied level of care, budget adjustment, suspension, reduction or termination of services are issued written notification of appeal rights at the time of denial. These rights are contained as a part of the denial notices. All appeal rights are outlined in 907 KAR 1:563, "Medicaid Covered Services Hearings and Appeals" which requires written notification of appeal rights to the member and the continuation of waiver services if the appeal is requested within ten (10) calendar days of the date of the notification. The notices are generated electronically at the time of denial.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☐ No. This Appendix does not apply
- ☒ Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DMS provides for a reconsideration process that is operated currently by the QIO. The provider, recipient or guardian acting on behalf of the recipient may file a reconsideration request upon receipt of written notice of a denial of services or level of care. A written request for reconsideration must be postmarked or submitted to the QIO within ten (10) calendar days from the date of the written notice of denial. A denial may be overturned, upheld, or modified as a result of reconsideration. If the denial is not overturned or if the request for reconsideration is past the ten (10) day time frame, then the recipient can appeal the denial through the Medicaid appeal process and request an Administrative Hearing. The process is as follows:

1. The provider, recipient, or guardian acting on behalf of the recipient may file a reconsideration request upon receipt of written notice of a denial of services or level of care.

2. A written request for reconsideration must be postmarked or submitted to the QIO via facsimile within ten (10) calendar days from the date of the written notice of denial. If the request is postmarked or dated and time-stamped by the facsimile service more than ten (10) calendar days from the date of the denial, the request is invalid. As a result, an out of time frame letter will be generated that indicates that the request for reconsideration was untimely and not valid.
3. For timely and valid reconsideration requests, The QIO or DMS will conduct the reconsideration and render a determination within three (3) calendar days of the request.
4. Within two (2) business days of the reconsideration determination, a letter communicating the decision will be mailed to the recipient (or his/her guardian), and provider.

A denial may be overturned, upheld, or modified as a result of a reconsideration.

- If the reconsideration determination upholds the original decision to deny service(s) or level of care, the recipient, his/her legal guardian, or his/her representative (authorized in writing) may request an administrative hearing. Administrative hearings are handled by the Hearing and Appeals Branch of the Cabinet for Health and Family Services. For individuals who have a certified level of care and who are receiving services, DMS will pay for continuation of those services through the date a final decision is made, provided that the hearing request is submitted within the specified time frame.
- If the reconsideration determination overturns the original decision, a prior authorization will be issued.
- If the reconsideration determination modifies a portion of the original decision, the portion of the decision that remains denied may be further disputed by the recipient, his/her legal guardian, or his/her representative (authorized in writing) through an administrative hearing. For the portion of the decision that overturns the original decision, a prior authorization will be issued.

DMS provides for a reconsideration process that is operated and instituted by the QIO. The reconsideration process is not a pre-requisite or substitute for the Fair Hearing process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ☐ No. This Appendix does not apply
- ☒ Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Department for Medicaid Services

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants have the opportunity to register grievances/complaints concerning the provision of services by waiver providers. Waiver members may register any grievance/complaint regarding waiver service provision or service providers by contacting the Department for Medicaid Services. DMS will immediately assess the gravity of the grievance/complaint, and if a member's health, safety or welfare are jeopardized, will immediately respond. Other complaints/grievances will be addressed within five (5) business days. Complaints/grievances are tracked to determine if additional provider trainings should be developed and conducted.

In addition to the Department's grievance/complaint system, each waiver provider shall implement procedures to address member complaints and grievances. The providers are required to educate all members regarding the Department grievance/complaints process, including how to contact the state Ombudsman, the provider grievance/complaint system and provide adequate resolution in a timely manner. The provider grievances and appeals are monitored by the DMS through on-site monitoring during surveys, investigations and technical assistance visits.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)

☐ **No. This Appendix does not apply** (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(b) The following shall be the two (2) classes of incidents:

1. An incident; or

2. A critical incident.

(2) An incident shall be any occurrence that impacts the health, safety, welfare, or lifestyle choice of a participant and includes:

(a) A minor injury;

(b) A medication error without a serious outcome; or

(c) A behavior or situation that is not a critical incident.

(3) A critical incident shall be an alleged, suspected, or actual occurrence of an incident that:

(a) Can reasonably be expected to result in harm to a participant; and

(b) Shall include:

1. Abuse, neglect, or exploitation;

2. A serious medication error;

3. Death;

4. A homicidal or suicidal ideation;

5. A missing person; or

6. Other action or event that the provider determines may result in harm to the participant.

(4)(a) If an incident occurs, the ABI provider shall:

1. Report the incident by making an entry into the MWMA[portal] that includes details regarding the incident; and

2. Be immediately assessed for potential abuse, neglect, or exploitation.

(b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:

1. [The individual who discovered or witnessed the incident shall immediately act to ensure the health, safety, or welfare of the at-risk participant;

2.] The incident shall immediately be considered a critical incident;

3.[3.] The critical incident procedures established in subsection (5) of this section shall be followed; and

3.[4.] The ABI provider shall report the incident to the participant's case manager and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.

(5)(a) If a critical incident occurs, the individual who witnessed the critical incident or discovered the critical incident shall immediately act to ensure the health, safety, and welfare of the at-risk participant.

(b) If the critical incident:

1. Requires reporting of abuse, neglect, or exploitation, the critical incident shall be immediately reported via the MWMA [portal] by the individual who witnessed or discovered the critical incident; or

2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA[portal] by the individual who witnessed or discovered the critical incident within eight (8) hours of discovery.

(c) The ABI provider shall:

1. Conduct an immediate investigation and involve the participant's case manager in the investigation; and

2. Prepare a report of the investigation, which shall be recorded in the MWMA[portal] and shall include:

a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;

b. Details of the critical incident; and

c. Relevant participant information including:

(i) Axis I diagnosis or diagnoses;

(ii) Axis II diagnosis or diagnoses;

(iii) Axis III diagnosis or diagnoses;

(iv) A listing of recent medical concerns;

(v) An analysis of causal factors; and

(vi) Recommendations for preventing future occurrences.

(6) [If a critical incident does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA][portal] within eight (8) hours of discovery.

(7)(a) Following a death of a participant receiving ABI services from an ABI provider, the ABI provider shall enter mortality data documentation into the MWMA[portal] within fourteen (14) days of the death.

(b) Mortality data documentation shall include:

1. The participant's person-centered service plan at the time of death;

2. Any current assessment forms regarding the participant;

3. The participant's medication administration records from all service sites for the past three (3) months along with a copy of each prescription;
 4. Progress notes regarding the participant from all service elements for the past thirty (30) days;
 5. The results of the participant's most recent physical exam;
 6. All incident reports, if any exist, regarding the participant for the past six (6) months;
 7. Any medication error report, if any exists, related to the participant for the past six (6) months;
 8. The most recent psychological evaluation of the participant;
 9. A full life history of the participant including any update from the last version of the life history;
 10. Names and contact information for all staff members who provided direct care to the participant during the last thirty (30) days of the participant's life;
 11. Emergency medical services notes regarding the participant if available;
 12. The police report if available;
 13. A copy of:
 - a. The participant's advance directive, medical order for scope of treatment, living will, or health care directive if applicable;
 - b. Any functional assessment of behavior or positive behavior support plan regarding the participant that has been in place over any part of the past twelve (12) months; and
 - c. The cardiopulmonary resuscitation and first aid card for any ABI provider's staff member who was present at the time of the incident that resulted in the participant's death;
 14. A record of all medical appointments or emergency room visits by the participant within the past twelve (12) months; and
 15. A record of any crisis training for any staff member present at the time of the incident which resulted in the participant's death.
- (7)(8)(a) An ABI provider shall report a medication error to the MWMA[portal].
- (b) An ABI provider shall document all medication error details on a medication error log retained on file at the ABI provider site[

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The waiver provider shall have written policies and procedures detailing the processes regarding member rights to be free of abuse, neglect and exploitation. These policies and procedures include the process for filing complaints with the provider agencies and the contact information for the Department for Community Based Services (DCBS), Division of Permanency and Protection to initiate an investigation of the complaint. All policies and procedures, including DCBS contact information, are required to be provided to and explained to each member and/or guardian upon entry into the waiver program (Case Manager), entry into provider services and at each person centered team meeting.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

If an incident occurs, the ABI provider shall:

1. Report the incident by making an entry into the MWMA[portal] that includes details regarding the incident; and
 2. Be immediately assessed for potential abuse, neglect, or exploitation.
- (b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:
1. The individual who discovered or witnessed the incident shall immediately act to ensure the health, safety, or welfare of the at-risk participant;
 2. The incident shall immediately be considered a critical incident;
 3. The critical incident procedures established in subsection (5) of this section shall be followed; and
 4. The ABI provider shall report the incident to the participant's case manager and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.
- (5)(a) If a critical incident occurs, the individual who witnessed the critical incident or discovered the critical incident shall immediately act to ensure the health, safety, and welfare of the at-risk participant.
- (b) If the critical incident:
1. Requires reporting of abuse, neglect, or exploitation, the critical incident shall be immediately reported via the MWMA [portal] by the individual who witnessed or discovered the critical incident; or
 2. Does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA[portal] by the individual who witnessed or discovered the critical incident within eight (8) hours of discovery.
- (c) The ABI provider shall:
1. Conduct an immediate investigation and involve the participant's case manager in the investigation; and
 2. Prepare a report of the investigation, which shall be recorded in the MWMA[portal] and shall include:
 - a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;
 - b. Details of the critical incident; and
 - c. Relevant participant information
- (6) [If a critical incident does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the

MWMA][portal][within eight (8) hours of discovery.

The MWMA system alerts ABI Branch staff when incidents are reported by ABI LTC providers. ABI Branch staff review the reported incident for appropriate provider response and provide technical assistance, follow up or investigation as indicated. If investigation by ABI Branch staff is warranted, assignment of an investigation is made within 1 business day of receipt of incident to the appropriate investigator. The investigator will contact relevant individuals while seeking information which may include the participant and/or their guardian as well as the provider agency's staff. Upon completion of the investigation, any findings are identified and cited in a findings report that is sent to the provider agency for their corrective action response within 30 business days of the completion of the report. Providers must respond with the corrective action plan within 10 business days. The findings report is made available to other state agencies to include Medicaid, State Guardianship, Office of the Inspector General, Office of the Attorney General, Adult Protective Services, and others as needed and is also available to the public through an open records request. In situations where APS investigation is conducted, through inter-agency agreement, the resulting report is provided to the ABI Branch. Participants, their family members or legal representatives may request the information through the open records process.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

A Memorandum of Agreement between the Department for Community Based Services (DCBS) and the Department for Medicaid Services includes reporting and conducting collaborative investigations when incidents of abuse, neglect or exploitation occur when participants are enrolled in the ABI LTC waiver.

Upon receipt of critical incident notifications and/or final reports each incident is immediately screened to ensure that the provider agency has taken appropriate steps to ensure the health, safety, and welfare of the individual(s) involved. If concerns are identified by ABI Branch staff, immediate follow up is conducted with the provider and/or involved participant. Following the health, safety, and welfare screening, all critical incident reports are screened for the appropriateness of provider analysis and reaction.

When questions arise that make effective evaluation of the provider's activities impossible, provider staff members are contacted for immediate clarification.

Concerns that do not put individuals at needless risk are addressed by ABI Branch Staff by providing technical assistance to the provider for in-depth follow-up during their next scheduled technical assistance visit with the provider.

All complaints received by the ABI Branch are followed up by appropriate ABI Branch staff members.

If at any point during the process it is determined that the follow-up of an incident or complaint is complex, the incident or complaint is assigned to a certified investigator for on-site or desk level investigation. All findings require the submission of an acceptable corrective action plan that is monitored by ABI Branch staff for implementation and effectiveness.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☒ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

DMS recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of crisis prevention.

DMS is dedicated to fostering a restraint-free environment in all waiver programs. The use of mechanical restraints, seclusion, manual restraints including any manner of Prone (breast-bone down) or Supine (spine down) restraint is expressly prohibited.

The use of chemical restraint is expressly prohibited. A chemical restraint is the use of a medication either over the counter or prescribed, to temporarily control behavior, restrict movement or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a

psychotropic PRN shall be incorporated into the person centered service plan or participant summary.

The DMS ABI Branch is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints within the ABI LTC waiver.

- ☐ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. **Use of Restrictive Interventions.** *(Select one):*

- ☐ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- ☒ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Any interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior must be reviewed and approved on an annual basis by a Human Rights Committee.

When an individual's circle of support believes that a right restriction is necessary to maintain health, safety and welfare, the rights restriction must be reviewed and approved by a Human Rights Committee (HRC). The HRC must review sound documentation that less restrictive attempts to teach and support the individual to make an informed choice are not effective. The rights restriction must include a plan to restore the individual's rights and should be reviewed on at least an annual basis.

Utilization of restrictive interventions is monitored by ABI Branch staff as part of on-site monitoring and review processes, including monitoring and follow up of incident reports. ABI Branch staff also monitor individual's plan of care implementation and supports as a routine part of their visits to providers. Through this process, ABI Branch Staff can determine if technical assistance or additional training may be needed. This assistance may be provided in a variety of ways, as best suited to the identified issue, to include sharing of information, formal training event or consultation by ABI Branch staff.

Restrictive measures prohibited include withholding of food or hydration as a means to control or impose calm; access to a legal advocate or ombudsman; access to toilet, bath or shower; deprivation of medical attention or prescribed medications; deprivation of sleep; access to personal belongings; and access to natural supports.

A psychotropic PRN is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a person's mental illness or psychiatric condition. It shall be documented by a physician's order

which shall include drug, dosage, directions and reason for use. Psychotropic medication is that which is capable of affecting the mind, emotions, and behavior; commonly denoting drugs used in the treatment of mental illnesses. The protocol for use of a psychotropic PRN shall be incorporated into the person centered service plan. Every Case Manager and any staff person who will be administering medications must successfully complete Medication Administration training approved by DMS. This training is provided by an RN. Case Manager education requirements are: Has a bachelor's degree or a higher degree in a human service field from an accredited college or university; or Has a Bachelor's Degree in any other field from an accredited university; or is a Registered Nurse. Direct Support Professional is at least 18 years old and has a high school diploma or GED or is 21 years old.

A chemical restraint is the use of a medication either over the counter or prescribed, to control behavior, restrict movement, or the function of an individual and is not a standard treatment for the individual's medical or psychiatric diagnosis. The use of chemical restraint is never acceptable.

Utilization of restrictive interventions is monitored as part of individual critical incident review conducted by ABI Branch staff.

ABI Branch staff also monitor individual's plan of care implementation and supports as a routine part of their visits to providers. Through this process, DDID can determine that technical assistance may be needed. This assistance may be provided in a variety of ways, as best suited to the identified issue, to include sharing of information, formal training event or consultation by ABI Branch staff.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department for Medicaid Services, ABI Branch is responsible for overseeing, monitoring and investigating the use of restrictive interventions and assuring that State policy and safeguards are followed. This oversight occurs a minimum of annually and/or as indicated by reported incidents and is incorporated into annual certification visits, on-site monitoring and investigations. Oversight is also conducted through the collection of data related to reported incidents which include restrictive interventions, by monitoring participant plans of care and on-site review of provider records and activities. Data collection is accomplished through the maintenance of a comprehensive, internal incident reporting database maintained by DMS and by entry of incidents and related information into the MWMA portal system. Reports are generated a minimum of quarterly, and data is analyzed to identify trends and patterns and for the purpose of remediation and training opportunities to prevent re-occurrence. All reported incidences of PRN psychotropic intervention are reviewed and follow up conducted by ABI Branch staff for confirmation of appropriate physician order and included protocol and assurance of inclusion in the person centered service plan.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

☒ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DMS recognizes that person-centered thinking and planning is the key to prevention of risk of harm for all recipients. It is the responsibility of all service providers to utilize person centered thinking as a means of planning and crisis prevention.

DMS is dedicated to fostering a safe and healthy environment in all waiver programs. The use of seclusion including any form of time out is expressly prohibited.

The DMS ABI Branch is responsible for oversight of the person centered planning process which includes monitoring of case management reports, incident reports, and complaints; and conducting investigations as necessary.

☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ☐ **No. This Appendix is not applicable** (do not complete the remaining items)
- ☒ **Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Approved waiver providers are responsible for monitoring participant medication regimens in residential and day service settings. Waiver providers are required to follow the guidelines indicated below for administration of medication: Unless the employee is a licensed or registered nurse, ensure that staff administering medication:

1. Have specific training provided by a licensed medical professional and documented competency on cause and effect and proper administration and storage of medication which shall be provided by a nurse, pharmacist or medical doctor; and
 2. Document all medication administered, including self-administered, over-the-counter drugs, on a medication log, with the date, time, and initials of the person who administered the medication and ensure that the medication shall:
 - a. Be kept in a locked container;
 - b. If a controlled substance, be kept under double lock;
 - c. Be carried in a proper container labeled with medication, dosage, and time if administered to the ABI recipient or self-administered at a program site other than his or her residence; and
 - d. Be documented on a medication administration form and properly disposed of if discontinued; and
- In addition, waiver providers are required to have policy and procedures for on-going monitoring of medication administration, which must be approved by DMS.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DMS is responsible for oversight of medication management practices by approved waiver providers. This oversight begins before provider certification as a waiver provider, with review and approval of providers' policy and procedures for on-going monitoring of medication administration. Medication administration policies, practices and record-keeping will be assessed, and necessary interventions employed, as part of the annual certification and on-site monitoring process and during unannounced on-site technical assistance visits. In addition, medication errors must be reported through the incident reporting process and are reviewed by ABI Branch staff when reported for any needed follow up, technical assistance or investigation.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

- i. **Provider Administration of Medications.** Select one:

- ☐ **Not applicable.** (do not complete the remaining items)
- ☒ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** (complete the remaining items)

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver providers are required to follow the guidelines indicated below for administration of medication:

Unless the employee is a licensed or registered nurse, ensure that staff administering medication:

1. Have specific training provided by a licensed medical professional and documented competency on cause and effect and proper administration and storage of medication which shall be provided by a nurse, pharmacist or medical doctor; and
2. Document all medication administered, including self-administered, over-the-counter drugs, on a medication log, with the date, time, and initials of the person who administered the medication and ensure that the medication shall:
 - a. Be kept in a locked container;
 - b. If a controlled substance, be kept under double lock;
 - c. Be carried in a proper container labeled with medication, dosage, and time if administered to the ABI recipient or self-administered at a program site other than his or her residence; and
 - d. Be documented on a medication administration form and properly disposed of if discontinued; and

In addition, waiver providers are required to have policy and procedures for on-going monitoring of medication administration, which must be approved by DMS.

- iii. **Medication Error Reporting.** *Select one of the following:*

- ☒ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

All errors will be reported to the Department for Medicaid Services, through the incident reporting system (MWMA). Critical medication errors are reported to the Department for Community Based Services, the state agency responsible for investigating reports of abuse, neglect and exploitation in accordance with KRS Chapter 209. For waiver participants with a public guardian, all errors will be reported to the Division of Protection and Permanency, Department for Community Based Services.

- (b) Specify the types of medication errors that providers are required to *record*:

Medication errors which must be recorded will include missed doses, medication not within the administration window when due, wrong dose, wrong medication given or wrong route.

- (c) Specify the types of medication errors that providers must *report* to the State:

All medication errors must be reported to DMS, including missed doses, medication not within the administration window when due, wrong dose, wrong medication given or wrong route. Any medication error with or without a serious outcome shall be reported. Medication errors with a serious outcome shall be reported as a Critical Incident.

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:




- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department for Medicaid Services is responsible for monitoring waiver providers' performance in administration of medication. This oversight begins with review and approval of providers' policy and procedures for on-going monitoring of medication administration. Medication administration policies, practices and record-keeping will be assessed, and necessary interventions employed, as part of the certification and on-site monitoring process, which occurs at least annually. In addition, all medication errors must be reported through the incident reporting system (MWMA), and will be followed up immediately upon report.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of critical incidents that were reviewed by DMS to confirm that the incident was investigated by the appropriate entity within the required timeframes.

N=Number of class II critical incidents reviewed by DMS of confirm that the incident was investigated by the appropriate entity within the required time frames. D= Number of class III incidents reviewed.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of critical incidents that received follow up within required time frames.

N= Number of critical incidents that received follow up within the required timeframe. D=

Number of critical incidents received.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

Number and percent of critical incidents that were reported within required time frames. N= Number of critical incidents that were reported within the required time frame. D= Number of critical incidents reported.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of deaths reviewed by DMS. N= Number of deaths reviewed. D= Number of deaths.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- b. **Sub-assurance:** The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number of reported incidents in which staff training needs were identified. N=# of incidents in which staff trainings needs were identified. D=Total # of incidents reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Operating agency database or MWMA

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

Number of reported incidents in which needed systems changes were identified. N=Number of incidents in which needed systems changes were identified. D= Number of incidents reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Operating agency database or MWMA

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

**Number and percent of critical incident reports which indicated the inappropriate use of seclusion or restraints. N=Number reports with inappropriate use of seclusion or restraints
D=Number of critical incident reports which include the use of seclusion or restraints**

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/> <div style="text-align: right;"> ^ v </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> <div style="text-align: right;"> ^ v </div>

- d. **Sub-assurance:** The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number of participants for who had an annual ABI Health Screening Recommendations Checklist completed. N=# of participants receiving residential supports who have had an annual ABI Health Screenings Recommendation Checklist completed. D=# of participant residential charts reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

On-site records review or MWMA

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="text-align: right;"> <input type="text"/> <div style="text-align: right;"> ^ v </div> </div>
<input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: QIO		Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Statistically valid sample
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Provider agencies are certified by DMS or licensed by OIG annually, which includes monitoring of the employee records for criminal checks and abuse registry checks.

DMS performs first line monitoring and identifies deficiencies of the ABI waiver provider and requires a corrective action plan to address the deficiencies identified. During the recertification process, policy and procedures for training provider staff are reviewed and review of incident reports for the period of the review are completed to ensure health, safety and welfare.

DMS monitors the complaint process by examining the complaint logs and the results of client satisfaction surveys. DMS will monitor agency reporting and remediation of critical incidents both on an individual and agency level.

DMS requires providers to post the toll-free fraud and abuse hotline telephone number of the Office Inspector General for all staff, waiver participants, and their caregivers or legal representatives and other interested parties to have access to. The purpose of this hotline is to enable complaints or other concerns to be reported to the Office of the Inspector General. for the ABI LTC waiver program, it is the primary responsibility of the ABI Branch staff to monitor providers, identify problems and issues within the waiver program and monitor and ensure implementation of all provider plans of correction. Providers with identified deficiencies are subject to citation, monetary penalties, and remediation up to and including decertification as a Kentucky Medicaid Provider.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The state incident management system requires waiver providers to complete and submit the required incident report form and have a process in place for investigation, communication and prevention of incidents within specified timeframes. As DMS staff review incidents submitted, any issues needing immediate action are assigned to a designated DMS staff person for investigation to address through technical assistance with the provider agency within specified timeframes. Priority areas of the analysis include abuse, neglect, exploitation, medication errors and emergency restraint use.

Participant safeguards in the event of critical incidents include, immediate referral to Adult Protective Services, rendering of appropriate medical treatment, referral to appropriate law enforcement agency, and ensuring the individual is in a safe environment.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DMS contracts with the fiscal agent who in turn, contracts with the QIO. DMS currently receives a monthly Utilization Management Review report, that is generated by the fiscal agent, which lists the number of LOC's, POC's approved and denied, services approved and denied. In addition, DMS staff are currently working with the Fiscal Agent on updates to the Utilization Management report on inclusion of provider number, member number, and inclusion of changes in the LOC date which will effect the waiver segment in the MMIS. When the waiver segment date is interrupted, or dates found to not be consecutive, then the provider will not be paid for the dates they are out of compliance with the regulation. Should providers contact DMS inquiring as to why a claim denied, DMS will be able to determine which providers are repeat offenders. Providers can subsequently be contacted to request Plan of Corrections or potentially terminate providers who continue to be repeat offenders.

DMS will meet with the Fiscal Agent and the QIO at least quarterly to discuss administrative and monitoring findings which will help identify quality areas in need of improvement. Areas of discussion may include: oversight of the waiver, performance measures, incident reporting, data, and monitoring findings. Information and results of these CQI meetings will be compiled in the form of a report. Data reported will include progress related to performance measures, level of care determinations, service authorizations, incident reporting, and corrective action issued. This report information will be shared with interested stakeholders at quarterly meetings.

DMS continues to work on internal data base modifications to include information gathered during the 1st line monitoring process of the ABI waiver providers.

An area for improvement noted through analysis of quality assurance discovery and remediation is in regard to the sub-assurance that providers continually meet certification standards. The primary areas of non-compliance have been identified as medication administration, day training providing diversional activity, and health, safety, welfare concerns. Each area is being addressed. Data will continue to be collected, reviewed and action plans will be revised as needed. Provider certification lengths are determined by findings related to health, safety and welfare citations, and repeat citations from past reviews.

Quality Improvement strategies will be implemented at various levels as guided by data trends to include individual level; provider level; and statewide. Progress toward achieving outcomes shall be monitored at these levels as well with data flowing through all quality improvement efforts. Any training needed to assist with strategy implementation may be held face-to-face, videoconferencing or online learning modules.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Other Specify: Fiscal agent, QIO	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Electronic System Design Changes: The Commonwealth has just implemented an electronic Medicaid Waiver Management system (MWMA) to streamline processes across waivers. It will be used by all the Kentucky waivers: KY0.144, KY.0314, KY0.333, KY.0475, KY.0477, and KY.40146.

MWMA will provide automated capabilities around the intake, assessment, eligibility determination, plan of care, case management, incident management, PDS timesheet, and reporting functions performed by waiver service providers. MWMA will eventually integrate with kynect, Kentucky's healthcare connection, providing individuals and families with self-service access to manage their waiver program applications, service plans, services and PDS timesheets. Information about the system can be found here: <http://chfs.ky.gov/dms/mwma.htm#what>
Commonwealth staff across all waivers as well as technology staff will be involved in suggesting and designing any applicable system changes.

System of Practice Design Changes: The Commonwealth is in the process of working toward compliance with the final rule. Three areas where considerable strides have been made over the past couple of years have been toward compliance with conflict-free case management, service plans reflecting what is important to and important for each person, and the planning process including both risk assessment and risk mitigation. The targeted standards for improvement are person-centered planning and setting requirements. Commonwealth staff across all waivers is involved in these efforts.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Through analysis of data obtained from the MWMA, quality assurance surveys and certification reviews, recommendations for corrective action plans, etc., DMS will modify existing systems and trainings to ensure continuing quality and satisfaction. The DMS will continuously review all reports to identify changing trends so that proactive modifications may be implemented to ensure continuing quality care. DMS provides policy clarifications to the waiver providers to ensure appropriate implementation of program policy and any revisions as they occur.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department for Medicaid Services conducts annual program and billing audits of all waiver providers. These audits include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver member. DMS utilizes reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved Plan of Care (POC) will be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved POC and ABI LTC regulation (907 KAR 3:210), DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification audits, post payment audits and investigations.

The Department for Aging and Independent Living (DAIL), through contractual agreement, will conduct annual audits of the financial management services (FMS) entities. These audits include a post-payment review of Medicaid reimbursement to the Community Mental Health Centers for payment to the member's employees through participant directed opportunities. DAIL will be responsible for auditing twenty-five percent (25%) of all participant directed member records. DAIL will utilize reports generated from MMIS

reflecting each service billed for each member. Comparison of payments to member records, documentation and approved POC's shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with the approved POC, and ABI LTC regulation (907 KAR 3:210) DAIL shall notify DMS to initiate recoupment of the monies. Additional billing reviews will be conducted based on issues identified during these post payment audits.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. **Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.** (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of claims reviewed that were coded and paid in accordance with reimbursement methodology. N= Number of claims that were coded and paid in accordance with reimbursement methodology. D= Number of claims paid.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: QIO, Fiscal agent	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO, Fiscal agent	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number and percent of waiver service claims that were submitted for ABI waiver participants who were enrolled in the waiver on the service delivery date. N= Number of ABI waiver service claims that were submitted for participants who were enrolled in the waiver on the service delivery date. D= Number of ABI waiver service claims.

Data Source (Select one):**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input checked="" type="checkbox"/> Other Specify: QIO, fiscal agent	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: QIO, Fiscal agent	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number of rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. N=Number of rates that remain consistent with the approved rate methodology D=Number of service rates.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediary, QIO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent and QIO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DMS reviews and adds Edits/Audits to the Medicaid Management Information System (MMIS) periodically for program compliance and as policy is revised to ensure claims are not paid erroneously.
DMS reviews the CMS-372 report for accuracy prior to submission.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DMS provides technical assistance to certified providers on an ongoing basis. Providers found out of compliance submit and are held to a plan of correction (POC). DMS staff monitor the status and implementation of all plans of correction. DMS performs trainings upon request, and as indicated by program audits, of providers and provides technical assistance whenever the need is identified or requested. Should an enrolled provider fail to meet their POC, DMS would impose a moratorium and prohibit participant admissions until the provider attains compliance with the submitted plan of correction. DMS conducts no less than monthly monitoring during the moratorium period. If satisfactory compliance is not noted or identified during the monthly monitoring, DMS will terminate the provider's enrollment as a waiver provider. This termination would apply to all waivers as stated in 907 KAR 7:005.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Agent and QIO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Provider rates are established using a fee-for-service system. Provider rates for this waiver have historically been established based on other Kentucky 1915(c) waiver programs with similar services and target populations, as well as historical utilization. No changes in rate methodology or rates are included in this renewal application, in comparison with the currently approved waiver.

Rates are established by the Kentucky Department for Medicaid Services and incorporated into Kentucky Administrative Regulations. All new and amended administrative regulations are subject to a public comment process during promulgation. Part of the process of adopting administrative regulations requires that they are published by the Legislative Research Commission; that public comments are solicited and may be submitted in writing or by testimony at a public hearing; that the administrative agency responsible for the regulations must respond to all public comments and file a statement of consideration with the Legislative Research Commission; and that regulations are considered by two legislative committees prior to adoption. Interested individuals and groups may ask to be notified when regulations related to a certain subject, such as Medicaid waivers, are adopted or amended.

Payment rates are made available to waiver participants and family members, as well as advocacy groups, individual providers, provider associations and the general public through the administrative regulation process described above. In addition, waiver payment rates are available on the DMS web site on a continuing basis.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings for waiver services will flow directly from waiver providers to the Commonwealth's MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

☒ **No. State or local government agencies do not certify expenditures for waiver services.**

☐ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the

certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All ABI LTC waiver providers shall be enrolled with the Department for Medicaid Services (DMS), provider enrollment, and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to prevent non-enrolled provider claims from processing. DMS shall conduct audits of 100 % of the ABI LTC waiver providers annually. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a ABI LTC member. DMS shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to member records, documentation and approved Plan of Care (POC) shall be conducted.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS** *(select one):*

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system (s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- ☒ The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- ☐ The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- ☒ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ☐ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ☒ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☐ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability**I-3: Payment (5 of 7)****e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ☐ The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability**I-3: Payment (6 of 7)****f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ☒ Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- ☐ Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability**I-3: Payment (7 of 7)****g. Additional Payment Arrangements****i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ☒ No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- ☐ Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ☒ No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.

- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ☒ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☐ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** *Select one:*

☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☒ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Kentucky Administrative Regulations governing the ABI Long Term Waiver specify that reimbursement for residential services shall not include payment for room and board. Approved waiver providers will be paid a flat rate for residential services which is determined based on active treatment and support services costs, not the cost of room and board.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ☒ **No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- ☐ **Yes.** Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ **No.** The State does not impose a co-payment or similar charge upon participants for waiver services.
- ☐ **Yes.** The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (*if any are checked, complete Items I-7-a-ii through I-7-a-iv*):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

- a. Co-Payment Requirements.**
- ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

- a. Co-Payment Requirements.**

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

☒ No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

☐ Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	61840.98	6126.89	67967.87	179484.52	17048.88	196533.40	128565.53
2	61840.98	6427.11	68268.09	188279.26	17884.27	206163.53	137895.44
3	61840.98	6742.04	68583.02	197504.95	18760.60	216265.55	147682.53
4	61840.98	7072.40	68913.38	207182.69	19679.87	226862.56	157949.18
5	61840.98	7418.94	69259.92	217334.64	20644.18	237978.82	168718.90

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	400		400
Year 2	400		400
Year 3	400		400
Year 4	400		400
Year 5	400		400

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay was figured by using the previous waiver years 1-3 from the most current 372(S) reports, which indicated a trend that will max out at 365 days per year for the current waiver at year 5; therefore, this renewal will use an ALOS of 365 for years 1, 2, 3, 5 and 366 for year 4, because of leap year in 2020.

Data referenced above:

7/1/11-6/30/12 Year 1 - Reported on 372(S) ALOS was 309

7/1/12-6/30/13 Year 2 - Reported on 372(S) ALOS was 334

7/1/13-6/30/14 Year 3 - Reported on 372(S) ALOS was 341

7/1/14-6/30/15 Year 4 - Forecasted based on previous 3 years data, ALOS will be 358

7/1/15-6/30/16 Year 5 - Forecasted based on previous 3 years data and projected year 4 the ALOS will be 366 (2016 is a leap year).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

From the most recent 372(s) report dated 07/01/2013 – 06/30/2014 (Waiver Year 3), the number of units per service reported has been increased by 74% for this renewal. This is because the renewal waiver has a projected increase of 74% of unduplicated waiver members to be served (from 230 to 400).

The number of users per service was also increased by 74%; this is to offset the expected increase in unduplicated waiver members from 230 to 400. The average units per user remain flat as reported in the most recent 372(s) report dated 07/01/2013 – 06/30/2014. Because there is not a proposed increase in reimbursement for waiver services, the average cost per unit remains the same as the previous waiver. The reimbursement methodology, including units and unit costs, has been derived from the regulation: 907 KAR 3:210. Acquired brain injury long-term care waiver services and reimbursement (<http://www.lrc.state.ky.us/kar/907/003/210.htm>) at the time of the renewal submission.

The component cost was derived by multiplying the number of users by the average number of units per user, and multiply that product by the average cost per unit. By summing the component costs and dividing by the number of unduplicated waiver members to be served, the Factor D is derived. The overall decrease in Factor D is because of the removal of assessment/reassessments, physical therapy, occupational therapy, and speech therapy services that were previously billed through the waiver. The assessment/reassessments will now be performed by the DMS, and the therapies are available in the Medicaid State Plan.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was determined by trending forward the CMS 372(s) report dated 07/01/2013 – 06/30/2014 (Waiver Year 3) with an annual trend factor of 4.9%. The forecasted increases were calculated using data from the NHE Fact Sheet, for 2014-24, which indicates health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita basis). <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was determined by trending forward the CMS 372(s) report dated 07/01/2013 – 06/30/2014 (Waiver Year 3) with an annual trend factor of 4.9%. The forecasted increases were calculated using data from the NHE Fact Sheet, for 2014-24, which indicates health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita

basis). <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was determined by trending forward the CMS 372(s) report dated 07/01/2013 – 06/30/2014 (Waiver Year 3) with an annual trend factor of 4.9%. The forecasted increases were calculated using data from the NHE Fact Sheet, for 2014-24, which indicates health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita basis). <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Adult Day Health Care	
Adult Day Training	
Conflict-free Case Management	
Respite	
Supported Employment	
Behavior Services	
Counseling	
Goods and Services	
Group Counseling	
Nursing Supports	
Specialized Medical Equipment	
Financial Management Services	
Community Living Supports	
Environmental and minor home modifications	
Family Training	
Supervised Residential Care Level I	
Supervised Residential Care Level II	
Supervised Residential Care Level III	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						165.88
Adult Day Health Care	15 minutes	2	26.00	3.19	165.88	
Adult Day Training Total:						3035339.58
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Training	15 minutes	237	3178.00	4.03	3035339.58	
Conflict-free Case Management Total:						1650000.00
Conflict-free Case Management	1 month	400	11.00	375.00	1650000.00	
Respite Total:						236304.00
Respite	15 minutes	27	2188.00	4.00	236304.00	
Supported Employment Total:						27211.80
Supported Employment	15 minutes	11	310.00	7.98	27211.80	
Behavior Services Total:						1271869.62
Behavior Services	15 minutes	159	238.00	33.61	1271869.62	
Counseling Total:						1418956.80
Counseling	15 minutes	248	240.00	23.84	1418956.80	
Goods and Services Total:						168000.00
Goods and Services	Each	21	16.00	500.00	168000.00	
Group Counseling Total:						4025.00
Group Counseling	15 minutes	20	35.00	5.75	4025.00	
Nursing Supports Total:						78050.00
Nursing Supports	15 minutes	14	223.00	25.00	78050.00	
Specialized Medical Equipment Total:						500.00
Specialized Medical Equipment	Each	2	1.00	250.00	500.00	
Financial Management Services Total:						104575.00
Financial Management Services	15 minutes	94	89.00	12.50	104575.00	
Community Living Supports Total:						7374294.72
Community Living Supports	15 minutes	234	5668.00	5.56	7374294.72	
Environmental and minor home modifications Total:						214000.00
Environmental and minor home modifications	Each	107	2.00	1000.00	214000.00	
Family Training Total:						1800.00
Family Training	15 minutes	9	8.00	25.00	1800.00	
Supervised Residential Care Level I Total:						9106000.00
Supervised Residential Care Level I	1 Day	145	314.00	200.00	9106000.00	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supervised Residential Care Level II Total:						28800.00
Supervised Residential Care Level II	1 Day	4	48.00	150.00	28800.00	
Supervised Residential Care Level III Total:						16500.00
Supervised Residential Care Level III	1 Day	2	110.00	75.00	16500.00	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						165.88
Adult Day Health Care	15 minutes	2	26.00	3.19	165.88	
Adult Day Training Total:						3035339.58
Adult Day Training	15 minutes	237	3178.00	4.03	3035339.58	
Conflict-free Case Management Total:						1650000.00
Conflict-free Case Management	1 month	400	11.00	375.00	1650000.00	
Respite Total:						236304.00
Respite	15 minutes	27	2188.00	4.00	236304.00	
Supported Employment Total:						27211.80
Supported Employment	15 minutes	11	310.00	7.98	27211.80	
Behavior Services Total:						1271869.62
Behavior Services	15 minutes	159	238.00	33.61	1271869.62	
Counseling Total:						1418956.80
Counseling	15 minutes	248	240.00	23.84	1418956.80	
Goods and Services Total:						168000.00
Goods and Services					168000.00	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Each	21	16.00	500.00		
Group Counseling Total:						4025.00
Group Counseling	15 minutes	20	35.00	5.75	4025.00	
Nursing Supports Total:						78050.00
Nursing Supports	15 minutes	14	223.00	25.00	78050.00	
Specialized Medical Equipment Total:						500.00
Specialized Medical Equipment	Each	2	1.00	250.00	500.00	
Financial Management Services Total:						104575.00
Financial Management Services	15 minutes	94	89.00	12.50	104575.00	
Community Living Supports Total:						7374294.72
Community Living Supports	15 minutes	234	5668.00	5.56	7374294.72	
Environmental and minor home modifications Total:						214000.00
Environmental and minor home modifications	Each	107	2.00	1000.00	214000.00	
Family Training Total:						1800.00
Family Training	15 minutes	9	8.00	25.00	1800.00	
Supervised Residential Care Level I Total:						9106000.00
Supervised Residential Care Level I	1 Day	145	314.00	200.00	9106000.00	
Supervised Residential Care Level II Total:						28800.00
Supervised Residential Care Level II	1 Day	4	48.00	150.00	28800.00	
Supervised Residential Care Level III Total:						16500.00
Supervised Residential Care Level III	1 Day	2	110.00	75.00	16500.00	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						165.88
Adult Day Health Care	15 minutes	2	26.00	3.19	165.88	
Adult Day Training Total:						3035339.58
Adult Day Training	15 minutes	237	3178.00	4.03	3035339.58	
Conflict-free Case Management Total:						1650000.00
Conflict-free Case Management	1 month	400	11.00	375.00	1650000.00	
Respite Total:						236304.00
Respite	15 minutes	27	2188.00	4.00	236304.00	
Supported Employment Total:						27211.80
Supported Employment	15 minutes	11	310.00	7.98	27211.80	
Behavior Services Total:						1271869.62
Behavior Services	15 minutes	159	238.00	33.61	1271869.62	
Counseling Total:						1418956.80
Counseling	15 minutes	248	240.00	23.84	1418956.80	
Goods and Services Total:						168000.00
Goods and Services	Each	21	16.00	500.00	168000.00	
Group Counseling Total:						4025.00
Group Counseling	15 minutes	20	35.00	5.75	4025.00	
Nursing Supports Total:						78050.00
Nursing Supports	15 minutes	14	223.00	25.00	78050.00	
Specialized Medical Equipment Total:						500.00
Specialized Medical Equipment	Each	2	1.00	250.00	500.00	
Financial Management Services Total:						104575.00
Financial Management Services	15 minutes	94	89.00	12.50	104575.00	
Community Living Supports Total:						7374294.72
Community Living Supports	15 minutes	234	5668.00	5.56	7374294.72	
Environmental and minor home modifications Total:						214000.00
Environmental and minor home modifications	Each	107	2.00	1000.00	214000.00	
Family Training Total:						1800.00
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Training	15 minutes	9	8.00	25.00	1800.00	
Supervised Residential Care Level I Total:						9106000.00
Supervised Residential Care Level I	1 Day	145	314.00	200.00	9106000.00	
Supervised Residential Care Level II Total:						28800.00
Supervised Residential Care Level II	1 Day	4	48.00	150.00	28800.00	
Supervised Residential Care Level III Total:						16500.00
Supervised Residential Care Level III	1 Day	2	110.00	75.00	16500.00	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						165.88
Adult Day Health Care	15 minutes	2	26.00	3.19	165.88	
Adult Day Training Total:						3035339.58
Adult Day Training	15 minutes	237	3178.00	4.03	3035339.58	
Conflict-free Case Management Total:						1650000.00
Conflict-free Case Management	1 month	400	11.00	375.00	1650000.00	
Respite Total:						236304.00
Respite	15 minutes	27	2188.00	4.00	236304.00	
Supported Employment Total:						27211.80
Supported Employment	15 minutes	11	310.00	7.98	27211.80	
Behavior Services Total:						1271869.62
Behavior Services	15 minutes	159	238.00	33.61	1271869.62	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						366

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling Total:						1418956.80
Counseling	15 minutes	248	240.00	23.84	1418956.80	
Goods and Services Total:						168000.00
Goods and Services	Each	21	16.00	500.00	168000.00	
Group Counseling Total:						4025.00
Group Counseling	15 minutes	20	35.00	5.75	4025.00	
Nursing Supports Total:						78050.00
Nursing Supports	15 minutes	14	223.00	25.00	78050.00	
Specialized Medical Equipment Total:						500.00
Specialized Medical Equipment	Each	2	1.00	250.00	500.00	
Financial Management Services Total:						104575.00
Financial Management Services	15 minutes	94	89.00	12.50	104575.00	
Community Living Supports Total:						7374294.72
Community Living Supports	15 minutes	234	5668.00	5.56	7374294.72	
Environmental and minor home modifications Total:						214000.00
Environmental and minor home modifications	Each	107	2.00	1000.00	214000.00	
Family Training Total:						1800.00
Family Training	15 minutes	9	8.00	25.00	1800.00	
Supervised Residential Care Level I Total:						9106000.00
Supervised Residential Care Level I	1 Day	145	314.00	200.00	9106000.00	
Supervised Residential Care Level II Total:						28800.00
Supervised Residential Care Level II	1 Day	4	48.00	150.00	28800.00	
Supervised Residential Care Level III Total:						16500.00
Supervised Residential Care Level III	1 Day	2	110.00	75.00	16500.00	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						366

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate

and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Total:						165.88
Adult Day Health Care	15 minutes	2	26.00	3.19	165.88	
Adult Day Training Total:						3035339.58
Adult Day Training	15 minutes	237	3178.00	4.03	3035339.58	
Conflict-free Case Management Total:						1650000.00
Conflict-free Case Management	1 month	400	11.00	375.00	1650000.00	
Respite Total:						236304.00
Respite	15 minutes	27	2188.00	4.00	236304.00	
Supported Employment Total:						27211.80
Supported Employment	15 minutes	11	310.00	7.98	27211.80	
Behavior Services Total:						1271869.62
Behavior Services	15 minutes	159	238.00	33.61	1271869.62	
Counseling Total:						1418956.80
Counseling	15 minutes	248	240.00	23.84	1418956.80	
Goods and Services Total:						168000.00
Goods and Services	Each	21	16.00	500.00	168000.00	
Group Counseling Total:						4025.00
Group Counseling	15 minutes	20	35.00	5.75	4025.00	
Nursing Supports Total:						78050.00
Nursing Supports	15 minutes	14	223.00	25.00	78050.00	
Specialized Medical Equipment Total:						500.00
Specialized Medical Equipment	Each	2	1.00	250.00	500.00	
Financial Management Services Total:						104575.00
Financial Management Services	15 minutes	94	89.00	12.50	104575.00	
Community Living Supports Total:						7374294.72
Community Living Supports	15 minutes	234	5668.00	5.56	7374294.72	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental and minor home modifications Total:						214000.00
Environmental and minor home modifications	Each	107	2.00	1000.00	214000.00	
Family Training Total:						1800.00
Family Training	15 minutes	9	8.00	25.00	1800.00	
Supervised Residential Care Level I Total:						9106000.00
Supervised Residential Care Level I	1 Day	145	314.00	200.00	9106000.00	
Supervised Residential Care Level II Total:						28800.00
Supervised Residential Care Level II	1 Day	4	48.00	150.00	28800.00	
Supervised Residential Care Level III Total:						16500.00
Supervised Residential Care Level III	1 Day	2	110.00	75.00	16500.00	
GRAND TOTAL:						24736392.40
Total Estimated Unduplicated Participants:						400
Factor D (Divide total by number of participants):						61840.98
Average Length of Stay on the Waiver:						365